85-148
No. ___

Office-Supreme Court, U.S.
FILED
JUL 26 1985
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

BLUE CROSS and BLUE SHIELD OF MICHIGAN,
a nonprofit Michigan corporation,

Appellant,

—against—

WILLIAM G. MILLIKEN, Governor of the State of Michigan, FRANK J. KELLEY, Attorney General of the State of Michigan, and NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan,

Appellees.

ON APPEAL FROM THE SUPREME COURT OF MICHIGAN

APPENDIX TO JURISDICTIONAL STATEMENT

Of Counsel:
RANDOLPH S. SHERMAN
JOEL KATCOFF

STANLEY D. ROBINSON
Kaye, Scholer, Fierman,
Hays & Handler
425 Park Avenue
New York, New York 10022
(212) 407-8000

Attorney for Appellant

Of Counsel:
WILLIAM M. SAXTON
KEEFE A. BROOKS
Butzel Long Gust Klein
& Van Zile
1881 First National Building
Detroit, Michigan 48226
(313) 963-8142

350 pp

APPENDIX

TABLE OF CONTENTS

	PAGE
Opinion of the Michigan Supreme Court, April 16, 1985 (reported at 422 Mich. 1; 367 N.W.2d 1)	1a
Ingham County Circuit Court Order of Preliminary Injunction, April 2, 1981	130a
Ingham County Circuit Court Order of Preliminary Injunction, July 31, 1981	132a
Michigan Supreme Court Order Directing Circuit Court to Certify Controlling Questions of Public Law, March 25, 1982	134a
Ingham County Circuit Court Certification of Controlling Questions of Public Law and Statement of Need to Conduct Evidentiary Hearings, April 15, 1982	138a
Ingham County Circuit Court Findings of Relevant Facts, November 1, 1982	149a
Ingham County Circuit Court Supplement to Findings of Relevant Facts, November 9, 1982	243a
Michigan Supreme Court Judgment, April 16, 1985	245a
Michigan Supreme Court Order Denying Motion for Rehearing, June 24, 1985	247a
Notice of Appeal, July 10, 1985	249a
Michigan Nonprofit Health Care Corporation Reform Act, 1980 PA 350, MCL 550.1101 *et seq.*; MSA 24.660 (101) *et seq*	251a

Opinion of the Michigan Supreme Court, April 16, 1985
(reported at 422 Mich. 1; 367 N.W.2d 1)

9

State of Michigan

SUPREME COURT

Docket No. 68903—Argued October 4, 1983
(Calendar No. 1)—Decided April 16, 1985

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a non-profit Michigan corporation,

Plaintiff,

—v.—

WILLIAM G. MILLIKEN, GOVERNOR OF THE STATE OF MICHIGAN, FRANK J. KELLEY, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

Butzel, Long, Gust, Klein & Van Zile, P.C. (by *William M. Saxton* and *Keefe A. Brooks*), for the plaintiff.

Frank J. Kelley, Attorney General, *Louis J. Caruso,* Solicitor General, and *Harry G. Iwasko, Jr.,* and *Deborah K. Canja,* Assistants Attorney General, for the defendants.

Amicus Curiae:

Dickinson, Wright, Moon, Van Dusen & Freeman (by *John Corbett O'Meara* and *Timothy H. Howlett*) for Chrysler Corporation.

OPINION OF THE COURT

WILLIAMS, C.J. This case presents important questions of first impression regarding the constitutionality and construction of the Nonprofit Health Care Corporation Reform Act, 1980 PA 350, MCL 550.1101 *et seq.;* MSA 24.660(101) *et seq.*

Prior to April 3, 1981, the effective date of the act, BCBSM brought a complaint for declaratory

judgment challenging the constitutionality of the act and sought an injunction against the act's enforcement in the Ingham Circuit Court. On April 2, 1981, the Ingham Circuit Court enjoined the enforcement of the act and further ordered the parties to comply with the existing enabling acts, 1939 PA 108 and 109, as amended.[1] We initially granted leave to appeal from that order but, following BCBSM's motion for reconsideration, we took the matter under advisement.[2]

At the request of the Governor, pursuant to the certified-question rule,[3] we ordered the Ingham Circuit Court to certify the controlling question or questions of public law, to provide a statement of the relevant facts and, if needed, conduct evidentiary hearings. Evidentiary hearings were subsequently conducted over a two-month period, from July 27 to September 24, 1982, generating 4,000 pages of transcript and 194 exhibits.

On November 1, 1982, the circuit court filed its certified questions of public law and findings of

[1] 1939 PA 108 and 109, MCL 550.301 *et seq.*; MSA 24.591 *et seq.*; MCL 550.501 *et seq.*; MSA 24.621 *et seq.*, were to be repealed effective April 3, 1981 by 1980 PA 350.

[2] *Ins Comm'r v Blue Cross & Blue Shield of Michigan* and *Blue Cross & Blue Shield of Michigan v Governor*, 412 Mich 944 (1982).

[3] The certified-question rule involved here is GCR 1963, 797.1. It provides, in pertinent part:

".1 From Michigan Courts.

"(a) Whenever the judge or judges of any court, or the officers of any tribunal, from which an appeal of right or otherwise may be taken to the Court of Appeals or to the Supreme Court, has pending before him or them any controlling question or questions of public law involved in a pending case or controversy, and such question or questions are of such public moment as to require early determination according to executive message of the Governor addressed to the Supreme Court, the Supreme Court in its discretion may authorize such judge or officers to certify such question or questions to the Supreme Court with a statement of the facts relevant thereto sufficient to make clear the application of such question or questions, and further proceedings relative to such case or controversy shall thereupon be stayed to such extent as the judge or officers shall by order direct, pending receipt of an answer from the Supreme Court."

relevant facts, consisting of 562 findings. The parties agreed that the essence of the circuit court's certification of controlling questions of public law is set forth in BCBSM's "Questions Presented." Those questions follow:[4]

> I. Does PA 350 unconstitutionally impair the existing contract between BCBSM and the State of Michigan?
> II. Does PA 350 deprive BCBSM of liberty and property without due process of law by effectively converting a heretofore private corporation into a public, governmental corporation?
> III. Does PA 350 constitute an unconstitutional delegation of legislative authority to BCBSM and other private persons?
> IV. Do sections 203, 206(4), 211, 301(7), 302(1), 305(1), 509(4)(b), 510 and/or 516(2)(b) of PA 350 unconstitutionally impair private, vested contract rights between BCBSM and its members, participating providers and customers?
> V. Do sections 104(3), 206(4), 211, 217, 401(7), 414a, 415, 502(1)(b) and/or 607(1) of PA 350 deprive BCBSM of liberty and property without due process of law by regulating BCBSM in an arbitrary and discriminatory manner which bears no real and substantial relationship to the objects of PA 350 or to the general health and welfare of the people of this state?
> VI. Do sections 104(3), 206(4), 211, 414a, 515 and/or 607(1) of PA 350 deprive BCBSM of the equal protections of the laws by regulating BCBSM in an arbitrary and discriminatory manner which bears no rational relationship to the objects of PA 350?

---

[4] BCBSM's brief includes an additional Question:

"X. Does PA 350 violate article 4, section 29 of the Michigan Constitution of 1963 by creating a corporation by special act?"

We do not address Question X, although it is briefed by the parties, since this was not one of the questions certified to this Court by the circuit judge. In *City of Gaylord v Gaylord City Clerk*, 378 Mich 273, 287, n 1; 144 NW2d 460 (1966), we noted that "[w]henever this unusual procedure is invoked, the parties should address themselves to the questions as certified." GCR 1963, 797.1(a).

VII. Do sections 402(7), 404(5), 605 and/or 701(5) of PA 350 deprive BCBSM of liberty and property without due process of law by providing for administrative procedures lacking in fundamental due process guarantees?

VIII. Do sections 106(5), 205(4), 205(5), 310(1), 401(1), 503, 504(1), 509(1), 509(4)(b), 510(1), 511(1) and/or 513(1) of PA 350 deprive BCBSM of liberty and property without due process of law by imposing unconstitutionally vague and illusory duties on BCBSM and the Commissioner of Insurance?

IX. Does section 301(7) of PA 350 deprive BCBSM, its directors, officers and members of guaranteed rights of free speech?

We do not agree with BCBSM's challenges to sections of 1980 PA 350 except in the following three particulars:

(1) Section 205(6) unconstitutionally delegates legislative power (Question 3);

(2) insofar as they pertain to administrative services only (ASO) contracts, §§ 104(3), 211, 414a, 415 and 607(1) violate equal protection (Questions 4, 5 and 6);

(3) § 402(7) establishes an improper burden of proof (Question 7).

Other sections of the act we do not address because there is no actual controversy presented:

(1) whether §§ 509(4)(b), 510 and 516(2)(b) impair the private existing contracts between BCBSM and its participating providers (Question 4);

(2) whether §§ 217 and 502(1)(b) deprive BCBSM of due process of law (Question 5);

(3) whether §§ 402(7), 404(5) and 605 fail to provide for an impartial decisionmaker in violation of due process of law (Question 7);

(4) whether §§ 106(5), 205(4), 205(5), 310(1), 401(1), 503, 504(1), 509(1), 509(4)(b), 510(1), 511(1) and/or 513(1) impose unconstitutionally vague and

illusory duties on BCBSM and the commissioner (Question 8);

(5) whether § 301(7) deprives BCBSM, its directors, officers and members of free speech (Question 9).

We sustain the act's constitutionality with regard to BCBSM's other challenges.

By way of preface, the length of this opinion is principally attributable to the fact that the nine certified questions contain no less than thirty-two issues, because BCBSM challenged forty-six sections of 1980 PA 350. Furthermore, in responding to BCBSM's multifarious style of attack, the opinion is necessarily somewhat redundant as a number of these sections challenged by BCBSM are attacked on several constitutional grounds, *i.e.*, as an impairment of BCBSM's public and private contractual rights, as a taking without due process of law, as violative of equal protection, as an unconstitutional delegation of legislative authority, as a denial of procedural due process, as unconstitutionally vague, and as a violation of the First Amendment.

I. HISTORICAL BACKGROUND

Because any new piece of legislation is not created in a vacuum, it will be helpful to examine, from an historical perspective, the critical factors which led to this major legislative reform, 1980 PA 350, in the state's health care delivery system.

Michigan's first health care enabling legislation originated in the 1930s as an outgrowth of the Great Depression where pervasive poverty among the people caused them to forgo needed health care services which, in turn, resulted in financial uncertainty for hospitals and physicians. The main purpose of the enabling legislation was, through the mechanism of prepaid group health care plans,

"to promote a wider distribution of medical care" to those people who otherwise did not have the financial resources to obtain health care services. The special legislation had a secondary purpose of protecting the public from fraud by placing the health care corporations charged with administering the plans under the regulatory authority of the Commissioner of Insurance. See *Blue Cross & Blue Shield of Michigan v Ins Comm'r*, 403 Mich 399, 419-425; 270 NW2d 845 (1978).[5]

The two predecessor corporations of BCBSM were incorporated pursuant to this original enabling legislation, under separate but comparable statutes.[6] A 1974 amendment to the enabling legislation allowed for the consolidation of these two corporations with the provision that the regulatory power of the Insurance Commissioner over the constituent corporations would remain the same with respect to the consolidated corporation.[7] The consolidation occurred in 1975, resulting in the formation of BCBSM.

BCBSM is a unique statutory creation, distinct from a private insurance company in that " 'it is not carried on as an insurance business for profit . . ., but rather it provides a method for promoting the public health and welfare in assisting . . . persons to budget' health care costs." *Blue Cross & Blue Shield of Michigan, supra*, p 418; see also *Michigan Hospital Service [Blue Cross] v Sharpe*, 339 Mich 357, 370; 63 NW2d 638 (1954). Under its enabling legislation, BCBSM is not "subject to the laws of this state with respect to insurance corporations, except as provided in [the] act . . . [nor]

[5] For an excellent review of the founding of Blue Cross plans in general and Michigan Blue Cross in particular, see Payton & Powsner, *Regulation through the looking glass: Hospitals, Blue Cross, and certificate-of-need*, 79 Mich L R 203, 214-232 (1980).

[6] See n 1.

[7] MCL 550.309a; MSA 24.599(1) and MCL 550.503b; MSA 24.623(2).

with respect to corporations generally." § 201(4). Rather, BCBSM is, by legislative declaration, a nonprofit "charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state." §§ 105(2), 201(5). In part by virtue of its favored status, in part by virtue of its health care delivery concept, and in part by virtue of the expertise and aggressiveness of its management, BCBSM has achieved a dominant position in the health care market, currently providing health care coverage to nearly sixty percent of the state's population.[8] It has participation contracts with all but four of the non-state-owned hospitals in the state and with approximately seventy percent of all the physicians. It also administers the federal Medicare program.[9] BCBSM has no shareholders and is managed by corporate officers and a board of directors.[10] The board of directors has in the past been nominated from the corporate members and elected by the same body with the exception of two public appointees of the Insurance Commissioner.[11] Historically, provider members on the board of directors have far outnumbered subscribers.[12] Only in recent years has the number of consumer representatives on the board increased.

During the past twenty years, national and statewide expenditures on medical care increased at a rapid rate almost double the rate of inflation. In 1960, national health care expenditures were 5.2 percent of the gross national product. By 1978, the proportion had jumped to 9.1 percent, an

[8] See Circuit Court's Findings of Relevant Facts, No. 3(a).

[9] See Circuit Court's Findings of Relevant Facts, No. 3(a).

[10] See Circuit Court's Findings of Relevant Facts, No. 86.

[11] MCL 550.308; 550.502; MSA 24.598; 24.622; see Circuit Court's Findings of Relevant Facts, Nos. 73, 75, 95, 96.

[12] See *Blue Cross & Blue Shield of Michigan v Ins Comm'r*, 403 Mich 399, 418; 270 NW2d 845 (1978).

overall increase of seventy-five percent. Michigan's figures for health care expenditures over the same years paralleled those of the nation.[13] While a combination of market forces is responsible for the spiraling costs, some of which are not within BCBSM's control, BCBSM can nonetheless have a significant influence in determining market prices because of its virtual dominance over delivery of the state's health care.[14] To some degree BCBSM has, through its policies, implemented cost containment programs; yet despite these efforts, Michigan's health care costs are among the highest in the country.[15] The elderly, low income and business sectors of this state have been especially burdened by the ever-increasing costs.[16]

As health care costs were mounting, BCBSM became the target of considerable controversy. The circuit court reported that much of the criticism voiced against BCBSM was centered on its secretive and closed system of board operation, its unresponsiveness to consumer interests and its ineffectiveness in containing the rapid escalation of health care costs.[17]

In the midst of the concern with escalating health care costs, this Court issued its opinion in *Blue Cross & Blue Shield of Michigan v Ins Comm'r,* 403 Mich 399; 270 NW2d 845 (1978),

[13] See Circuit Court's Findings of Relevant Facts, Nos. 10, 12, 259, citing defendant's Exhibit 33, State Health Plan for Michigan 1979-1983.

[14] See Circuit Court's Findings of Relevant Facts, Nos. 3(a), 173, 216.

[15] See Circuit Court's Findings of Relevant Facts, Nos. 15, 18, 245.

[16] See Circuit Court's Findings of Relevant Facts, Nos. 3(b), (c), (d), (f), 257.

[17] See Circuit Court's Findings of Relevant Facts, No. 3(e); defendant's Exhibit 96, "SAS" Senate Analysis Section report on House Bill 4555 (Substitute S-1); see also Hollister & Drake, *The Nonprofit Health Care Corporation Reform Act of 1980,* 14 Mich J L Ref 433 (1981); Law, *Blue Cross: What Went Wrong?* (New Haven: Yale University Press, 1974).

which addressed the issue whether and to what extent the Insurance Commissioner had the power to control costs pursuant to his or her regulatory authority over BCBSM. In noting that the commissioner's regulatory authority was not inherent but was derived solely from statute, this Court held that under 1939 PA 108 and 109 the commissioner possessed continuing statutory authority over BCBSM to approve or to disapprove "rates of payment by the corporation to hospitals that provide service to the corporation's subscribers," but not to physicians. *Id.*, p 431. This Court observed that the statute empowering the commissioner to regulate such rates did not set forth standards to guide the commissioner in exercising that power. *Id.*, p 428. This Court filled the gap by construing the enabling legislation broadly, finding that the Legislature intended the commissioner to regulate such rates only according to a "fair and reasonable" standard. *Id.*, pp 428-429. This Court concluded that while the commissioner could consider wasteful expenditures in determining whether an increase in the rates of payment by BCBSM to hospitals was fair and reasonable, the commissioner did not have the authority under the forty-year-old enabling acts to require specific cost containment programs. *Id.*, 413, 429. Thus, the commissioner's hands were tied against effectively combating the rising costs of health care services.

The Legislature responded quickly, and within two years of the *Blue Cross* decision 1980 PA 350 was passed and signed into law on December 29, 1980. One of the groups instrumental in developing the legislation was BCBSM.

The legislative history of the act indicates that it is designed to meet and remedy the problems raised by *Blue Cross, supra,* in that it broadens the commissioner's power to regulate BCBSM's rates for

both hospital and physician services and clarifies the standards to be followed by the commissioner in exercising this power.[18] Moreover, the act is intended to increase subscriber and public representation on the board of directors and to reorganize the internal operations of BCBSM so as to ensure its accountability to the public it was created to serve. Further, the primary objective of the act is to check rising health care costs by implementing definite cost containment goals with respect to provider reimbursement arrangements and providing greater incentives for BCBSM to develop cost-efficient programs, all subject to the supervisory powers of the Insurance Commissioner.[19] Overall, the act represents an effort of the Legislature aimed at curbing the rise on health care costs by a unique statutory scheme which combines both free-market and government regulatory methods of control.[20]

II. QUESTION 1

"I. DOES PA 350 UNCONSTITUTIONALLY IMPAIR THE EXISTING CONTRACT BETWEEN BCBSM AND THE STATE OF MICHIGAN?"

---

[18] See Hollister & Drake, n 17 *supra*, for a general discussion of the legislative history surrounding the enactment of 1980 PA 350.

[19] See n 18.

[20] The tension between increased government intervention on the one hand and free market forces on the other as means to achieve containment of health care costs has been the topic of current debate among health care analysts and commentators. See Havighurst, *Deregulating the Health Care Industry* (Ballinger Publishing Co: Cambridge, Mass, 1982); Yaggy & Anlyan, Eds., *Financing Health Care: Competition versus Regulation* (Ballinger Publishing Co: Cambridge, Mass, 1982); Lynk, *Regulation & Competition: An Examination of "The Consumer Choice Health Plan,"* 6 J Health, Politics, Policy & L 625 (1982); *A Special Symposium: Market-Oriented Approaches to Achieving Health Policy Goals*, 34 Vand L R 849 (1981); Wing & Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 NC L R 1165 (1979); *Symposium: Health Care: Parts I & II*, 35 Law & Contemp Problems 229, 667 (1970).

BCBSM claims that numerous sections of the act, when considered together, impair the public contract existing between the State of Michigan and BCBSM, as embodied in 1939 PA 108 and 109, its 1975 restated articles of incorporation and its bylaws, in violation of US Const, Art I, § 10 and Const 1963, art 1, § 10.[21]

A. *BCBSM's Reliance on Dartmouth College is Misplaced*

BCBSM bases its claim of 1980 PA 350's unconstitutionality in no small part on the premise that it is a private corporation and that any intrusion on its operations by the provisions of 1980 PA 350 impairs its contract with the state. The Attorney General, on the other hand, contends that BCBSM is a quasi-public corporation and, as such, has the responsibility to act in the public interest.

In support of its claim, BCBSM places great reliance on the well-known case of *Trustees of Dartmouth College v Woodward*, 17 US 518 (4 Wheat); 4 L Ed 629 (1819). The *Dartmouth College* case stands for the principle that the charter of a private corporation is a contract and any modification of a corporation charter by a state in the absence of a specific reservation of power violates the Contract Clause.

We find BCBSM's reliance to be misplaced. *Dartmouth College* reflects an earlier era of Contract Clause analysis. *Allied Structural Steel Co v Span-*

[21] The charter of a corporation, whether conferred by special act or under the general incorporation laws, is a contract between the state and the corporation, the corporation and the stockholders, and the stockholders and the state. *Bruun v Cook*, 280 Mich 484, 491; 273 NW 774 (1937); *Harsha v Detroit*, 261 Mich 586, 590; 246 NW 849 (1933). We are concerned here with the contractual relation between the state and the corporation. The latter two contractual relations are the subject of our discussion in Part V addressing BCBSM's impairment of private contracts claims.

naus, 438 US 234, 241; 98 S Ct 2716; 57 L Ed 2d 727 (1978). Beginning with the landmark case of *Home Building & Loan Ass'n v Blaisdell,* 290 US 398; 54 S Ct 231; 78 L Ed 413 (1934), the modern United States Supreme Court has construed the Contract Clause as not prohibiting a state from exercising its police power to abrogate private or public contracts if reasonably related to remedying a social or economic need of the community. Under modern Contract Clause analysis, a balancing approach has been adopted by the courts, weighing the degree of the impairment of the contractual rights and obligations of the parties against the justification for the impairment as an act of the state's police power to implement legislation for a legitimate public purpose. Michigan courts have followed this lead. See *Van Slooten v Larsen,* 410 Mich 21; 299 NW2d 704 (1980) (see in particular Justice LEVIN's dissenting opinion); *Metropolitan Funeral System Ass'n v Ins Comm'r,* 331 Mich 185, 194 *ff.;* 49 NW2d 131 (1951), and federal cases cited therein.[22]

This balancing test applies whether BCBSM is a private or quasi-public entity. Consequently, the question of BCBSM's corporate nature is not paramount to our resolution of the Contract Clause challenge, but, rather, as will be set forth below, the critical issue is whether and to what extent BCBSM has been regulated in the past. The more heavily regulated the industry, the less severe the

[22] Because this balancing approach directs our focus upon the permissible exercise of the state's police power in resolving the impairment of contract claim to 1980 PA 350, we need not reach the question raised by BCBSM whether the state possessed the reserved power to so modify BCBSM's 1975 corporate charter. See Conard, Ogders & Scanlon, *Corporations and the Michigan Constitution* (Constitutional Convention Preparatory Commission, State of Michigan, 1961), p 5, to the effect that "it is becoming increasingly clear that the state's police power can accomplish everything that the reserved power clause can where the 'public interest' is concerned."

impairment, if any, effected by state regulation since further regulation in the area should have been expected.

B. *The Constitutional Impairment of Contracts Standard is Now a Balancing Approach*

The new test for unconstitutional impairment of contracts is a balancing approach, weighing the extent of the impairment on the rights and obligations of the contracting parties against the state's police power to regulate in the public interest. A recent example of this balancing approach is found in the United States Supreme Court case of *Energy Reserves Group, Inc v Kansas Power & Light Co,* 459 US 400; 103 S Ct 697; 74 L Ed 2d 569 (1983), involving a federal Contract Clause challenge to the 1979 Kansas Natural Gas Price Protection Act which imposed price controls on the intrastate gas market. In its opinion upholding the statute, the Court noted the significance of the fact that the natural gas industry was heavily regulated at both the state and federal levels. *Id.,* p 582. We find particularly instructive the Court's clarification of the standard to be used for adjudicating contract impairment claims:

> The threshold inquiry is "whether the state law has, in fact, operated as a substantial impairment of a contractual relationship." *Allied Structural Steel Co,* 438 US 244. See *United States Trust Co [v New Jersey],* 431 US [1,] 17 [97 S Ct 1505; 52 L Ed 2d 92 (1977)]. The severity of the impairment is said to increase the level of scrutiny to which the legislation will be subjected. *Allied Structural Steel Co,* 438 US 245. . . . In determining the extent of the impairment, we are to consider whether the industry the complaining party has entered has been regulated in the past. *Allied Structural Steel Co,* 438 US 242, n 13, citing *Veix*

> *v Sixth Ward Bldg & Loan Ass'n,* 310 US 32, 38 [60 S Ct 792; 84 L Ed 1061] (1940). ("When he purchased into an enterprise already regulated in the particular to which he now objects, he purchased subject to further legislation upon the same topic"). The Court long ago observed: "One whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them." *Hudson Water Co v McCarter,* 209 US 349, 357 [28 S Ct 529; 52 L Ed 828] (1908).
>
> If the state regulation constitutes a substantial impairment, the State, in justification, must have a significant and legitimate public purpose behind the regulation, *United States Trust Co,* 431 US 22, such as the remedying of a broad and general social or economic problem. *Allied Structural Steel Co,* 438 US 247, 249. Furthermore, since *Blaisdell,* the Court has indicated that the public purpose need not be addressed to an emergency or temporary situation. *United States Trust Co,* 431 US 22, n 19; *Veix v Sixth Ward Bldg & Loan Ass'n,* 310 US 39-40.
>
> • • •
>
> Once a legitimate public purpose has been identified, the next inquiry is whether the adjustment of "the rights and responsibilities of contracting parties [is based] upon reasonable conditions and [is] of a character appropriate to the public purpose justifying [the legislation's] adoption." *United States Trust Co,* 431 US 22. *[Id.,* 74 L Ed 2d 580-581.]

The federal balancing approach has been adopted by our Court for purposes of adjudicating state Contract Clause claims as well as federal Contract Clause claims. See *Van Slooten v Larsen, supra; Metropolitan Funeral System Ass'n v Ins Comm'r, supra.* Thus, in scrutinizing Contract Clause claims under the state and federal constitu-

tions, the aforementioned cases establish the following standard:

1—The first inquiry is "whether the state law has, in fact, operated as a *substantial* impairment of a contractual relationship" (emphasis added). *Allied Structural Steel Co v Spannaus,* 438 US 244.

2—A critical factor to be considered in determining the extent of the impairment is "whether the industry the complaining party has entered has been regulated in the past." *Energy Reserves, supra.*

3—If the impairment is minimal, then there is no unconstitutional impairment of contract and our inquiry may end at this step.

4—If, however, the impairment is severe, then there are two further inquiries, both of which must be affirmatively shown to justify the legislative impairment:

a) Is there a significant and legitimate public purpose behind the regulation, *and*

b) If there is a legitimate public purpose, are the means adopted to implement the legislation reasonably related to the public purpose?

C. *Application of Standard to Challenged Statutory Schemata of the Act*

As we apply the aforementioned balancing test to the legislation at hand, we begin by analyzing the individual sections of 1980 PA 350 which BCBSM challenges. Once we analyze the sections individually, we can then determine whether collectively they fundamentally alter BCBSM's existing contract with the state.

The features of the act relevant here to BCBSM's impairment of public contract challenge follow.[23]

(1) *§§ 202(1)(d) and 401(1)—Corporate Duties*

In its attack on 1980 PA 350, BCBSM alleges that §§ 202(1)(d) and 401(1) of the act thrust upon it "[p]ublic welfare responsibilities . . ., as corporate duties, without its consent: *i.e.*, the duty to supply health care coverage to *all* residents of the State of Michigan and the duty to assure all subscribers access to quality health care services at a reasonable cost." (Emphasis in original.) BCBSM argues that 1980 PA 350, by imposing what are essentially governmental purposes on a private corporation, fundamentally alters its contract with the state, as embodied in 1939 PA 108 and 109 and its restated articles of incorporation.

We disagree.

Section 202(1)(d) states, in pertinent part, that a nonprofit health care corporation shall include among its corporate purposes:

(ii) To secure for all of the people of this state *who*

[23] BCBSM provides an inclusive list of those sections of 1980 PA 350 which are claimed to impair BCBSM's contract with the state. We address ourselves only to those sections of 1980 PA 350 specifically listed in plaintiff's appendix and will not therefore consider BCBSM's random reference to other sections of 1980 PA 350. For example, BCBSM, in a shotgun approach, mentions 1980 PA 350's statutory restrictions on packaging, § 206(4), ASO arrangements, § 211, per case participation, § 502(1)(b), and mandated subsidization of tax dollar supported and government owned mental health facilities, § 401(7), in connection with its impairment of public contract argument. Because none of these sections appear in plaintiff's appendix, we do not address them under this constitutional challenge.

Moreover, although BCBSM lists in its appendix § 304(1), which mandates that upon the request of a director, a subscriber shall receive a copy of the minutes of one or more meetings of the board, its committee, or the corporate body, as one of many sections which fundamentally alter BCBSM's contract with the state and also constitute a taking without due process, we do not address this section because whether such a request will ever be made is pure conjecture at this time and, thus, there is no "actual controversy" as to this challenge. See n 50 for discussion of the "actual controversy" requirement.

apply for a certificate, the opportunity for access to coverage for health care services at a fair and reasonable price.

(iii) To assure for nongroup and group *subscribers,* reasonable access to, and reasonable cost and quality of, health care services. [Emphasis added.]

Section 401 provides, in relevant part:

(1) A health care corporation established, maintained, or operating in this state shall *offer* health care benefits to all residents of this state . . . . [Emphasis added.]

We point out that BCBSM bases its argument that 1980 PA 350 imposes governmental purposes on a private corporation on its misinterpretation of the statutory language. Specifically, BCBSM misconstrues the above provisions by stating that it forces upon BCBSM the duty to supply health care services to *all* people of this state. A careful reading of the provisions leads us to a far different construction. Contrary to BCBSM's contention, only those state residents "who apply for a certificate," *i.e.,* its own customers, need be given the opportunity for access to health care services at a fair and reasonable price. The goal of assuring reasonable access to, and reasonable cost and quality of, health care services is limited to "subscribers" of the corporation. BCBSM is required only to *offer,* not to supply, health care benefits to all residents of this state. The act goes on to expressly provide that BCBSM is not prevented from denying coverage to an "individual [who] does not meet requirements for coverage contained in a certificate." § 401(4)(c).

We fail to see how these provisions thrust upon BCBSM public welfare responsibilities. Rather, they

place upon BCBSM nothing more than duties which BCBSM already owed to its own customers and to the public. Although under the former enabling acts, 1939 PA 108 and 109, BCBSM was not required to include legislated corporate purposes in its articles of incorporation, see 1939 PA 108, § 3, 1939 PA 109, § 4, it was subject to carry out the declared policy of 1939 PA 108, § 1, which was "to promote a wider distribution of medical care . . . in this state."

We find that the provisions of 1980 PA 350 here in question are not so dissimilar to the expressed legislative policy of the former enabling acts as to constitute a substantial impairment of BCBSM's existing contract with the state. Because we find that (1) the impairment, if any, is minimal, and (2) BCBSM has been regulated in the past, we need not further inquire as to whether the state has a legitimate purpose and has employed means both reasonable and of a character appropriate to that purpose. See Part II(B).

(2) *§ 203—Power to Amend Articles of Incorporation*

BCBSM further argues that § 203 operates to impair its contract with the state as embodied in Article VIII of its restated articles of incorporation, § 4 of 1939 PA 108 and § 5 of 1939 PA 109. Article VIII of the restated articles of incorporation, § 4 of 1939 PA 108, and § 5 of 1939 PA 109 empower the corporate membership of BCBSM to amend the restated articles of incorporation subject to the approval of the Attorney General and the Commissioner of Insurance. Section 203 of 1980 PA 350 places the power to amend and integrate the articles in the board of directors, subject to the approval of the Attorney General. BCBSM contends that this shifting of authority

from the corporate membership to the board of directors impairs its contract with the state.

We disagree.

In analyzing a Contract Clause claim, we must first ascertain whether the challenged legislative enactment works a substantial impairment of an existing contractual relationship. While we find that the provision in question transfers the power to amend BCBSM's articles of incorporation from the members to the directors, we fail to see how this is a substantial impairment of BCBSM's contract with the state where the industry has been subject to extensive state regulation in this area.

Under 1939 PA 108 and 109, the initial filing of BCBSM's articles of incorporation and any alteration of said articles thereafter was always subject to the regulatory authority of the commissioner and the Attorney General. See 1939 PA 108, §§ 3 and 4; 1939 PA 109, §§ 4 and 5. In light of this past extensive state regulation over BCBSM's articles, we deem the impairment, if any, under Act 350 to be unsubstantial.

Even had we found that § 203 is a substantial impairment of BCBSM's contract with the state, we still would have upheld its constitutionality under 4(a) and 4(b) of the balancing test. See Part II(B). To the extent § 203 impairs BCBSM's contractual interests, that section rests upon and is prompted by significant and legitimate state interests.

In recent years BCBSM has been the subject of considerable controversy. The evidence indicates that BCBSM has been unresponsive to consumers' interest. Additionally, critics have charged that BCBSM has not been vigorous in its cost containment efforts. The main reason alleged for these deficiencies is that BCBSM has been subject to undue and excessive provider and management influence. It is alleged that the providers and

management have gained control of the corporate membership. Because the power to elect the corporate members and the directors is derived from the restated articles of incorporation and articles I and IV of the bylaws, which the corporate members have the *sole authority* to amend, the providers and management have been able to perpetuate their positions. Section 203 seeks to ensure the equitable control of BCBSM by all interested parties.

To accomplish this purpose, the Legislature eliminated the corporate membership's sole power to amend the articles and has thereby reduced the possibility that any one group will dominate and control BCBSM. We believe that the means chosen to implement the legitimate public purpose are "reasonable . . . and . . . of a character appropriate to [that] purpose . . . ." Thus, we reject BCBSM's contention that by virtue of § 203 its contract with the state has been impaired within the meaning of the state or federal Contract Clause.

(3) *§§ 205(5), (10), 607 and 608—Power of the Commissioner over Lines of Business and Risk Factors, Contingency Reserves, Issuance of New Certificates & Rates*

BCBSM next contends that §§ 205(5) and (10), 607 and 608 (which basically give the Commissioner of Insurance approval power over BCBSM's lines of business, the risk factors assigned to those lines of business, contingency reserves, issuance of new certificates, rates and rating methods) impair BCBSM's contract with the state as embodied in 1939 PA 108 and 109, the restated articles of incorporation and the bylaws. BCBSM asserts that under these new sections the Commissioner of Insurance is now vested with "dictatorial powers over virtually every meaningful aspect of BCBSM's

business." BCBSM, however, fails to cite any section or provision of its existing contract with the state that has purportedly been impaired by these new sections. Nor is it clear from a review of the relevant sources which provisions BCBSM is relying upon.

In this light, we disagree with BCBSM's argument.

Again, the threshold question is whether the challenged provisions substantially impair BCBSM's existing contract with the state. Under BCBSM's existing contract with the state, the commissioner is given extensive approval power over contingency reserves, 1939 PA 108, § 11, 1939 PA 109, § 9, issuance of certificates, 1939 PA 108, § 5, 1939 PA 109, § 6, and rates, 1939 PA 109, § 3. See generally *Blue Cross & Blue Shield of Michigan v Ins Comm'r, supra*. Moreover, supervisory power is also exercised over risk factors and lines of business.[24] The authority exercised over BCBSM under the above provisions of 1980 PA 350 will be for all intents and purposes coextensive with that exercised under this existing system.[25] Consequently, (1) we are unable to find a substantial impairment, and (2) we recognize that health care corporations have always been subject to extensive regulation. We deem this conclusion so manifest that we need

[24] See Circuit Court's Findings of Relevant Facts Nos. 471-479; Testimony of Steven Henry, Tr Vol 18 pp 2949-2959; Defendant's Exhibit 72; BCBSM's Lines of Business.

[25] We recognize that to some degree the relevant sections of 1980 PA 350 give the commissioner more power than under the former system. For example, under § 205(5)(b) the commissioner is now empowered to define additional lines of business, and under § 205(10) the commissioner is empowered to formulate a plan to adjust the contingency reserve to the statutorily mandated level where the corporation is unable to formulate a satisfactory plan after two years. Nevertheless, in light of the commissioner's extensive approval power under the existing system and the fact that BCBSM has always been subject to broad and intrusive regulation, there is no substantial impairment.

not address the question whether the state has a legitimate purpose and has employed means both reasonable and of a character appropriate to that purpose. See Part II(B). We reject BCBSM's claim.

(4) *§§ 301(1)-(5), (7) and 305(1)—Corporate Board and Membership Structure*

Section 301(1)-(5) establishes the size of the board of directors and the composition thereof which includes four appointees of the Governor. Section 301(7) restricts the right of the corporate body, the incumbent board, the management, and members of each, to participate as such in the selection of the board, allowing participation only to the extent that the individual is a subscriber or to the extent that participation does not involve nomination, endorsement, approval or confirmation of a candidate or director. Section 301(7) additionally provides that the method of selection of subscriber representatives on the board "shall maximize subscriber participation to the extent reasonably practicable." Section 305(1) declares that the non-public corporate membership shall be selected in the same fashion as the non-public members of the board as set forth in § 301. That section also states that there shall be two non-public members for each non-public director. As to the public members, the four appointed directors are public members, and the Governor is authorized to appoint four additional public members, making a total of eight gubernatorially appointed public members.

As to all of the above sections, BCBSM argues that its contract with the state, consisting of 1939 PA 108 and 109, the restated articles of incorporation and the bylaws, has been substantially impaired. Again, BCBSM makes a broad statement that "PA 350 deprives BCBSM of the right to select its own directors and corporate members and

thereby deprives BCBSM of the fundamental right to select its own management . . . [and that] [t]hese changes substantially impair the object of BCBSM's charter and deprive BCBSM . . . of vested rights thereunder." Again, however, BCBSM fails to cite to this Court the provisions of its contract with the state that have been purportedly impaired. Nonetheless, for purposes of the discussion that follows, we will assume that BCBSM is referring to: Article V of the restated articles of incorporation, which states that directors shall be chosen in accordance with the bylaws; Article IV of the restated articles of incorporation which states that the members shall be chosen in accordance with the bylaws; and the relevant articles and sections of the bylaws pertaining to the selection of the board of directors and corporate membership. See Articles I and IV of BCBSM's bylaws.

In any event, we disagree with BCBSM's contentions.

Although to a certain extent the provisions in question impair BCBSM's right to select its own corporate management, we do not find this impairment to be substantial.

Under the existing contract with the state, the method of selection of BCBSM's directors and members were specified in the bylaws, the establishment of which was in the corporate members' exclusive domain, subject, however, to the approval of the commissioner and the Attorney General. Sections 301(6) and 305(1) of PA 350 states that the authority to establish the method of selection of the non-public directors and members shall be specified in the bylaws, which, in turn, has been placed in the control of the board of directors, subject as before to the Attorney General's approval. See § 302.

While it is conceivable that under the new act

the newly constituted board of directors could again vest the members with the power to select the non-public corporate members and directors, it is also conceivable that the members could be dispossessed of such power by the board of directors. What 1980 PA 350 has in effect done is divest the members of the *sole authority* they previously possessed to determine the method of selection of BCBSM's corporate management by transferring the locus of control over the bylaws from the members to the directors. We do not perceive this change to be substantial especially given the fact that BCBSM's bylaws have always been subject to extensive state regulation. The members took their position with knowledge of the regulatory powers of the state over the corporation's bylaws.

BCBSM further contends that 1980 PA 350's legislatively mandated structure of the board of directors and corporate members has impaired BCBSM's contractual right to "control its own corporate structure . . . and to thereby control its own corporate destiny." We assume that by this BCBSM means that it does not have the right to control its destiny because to a significant extent it does not have the right to determine the composition and size of its board and corporate body. While we agree that BCBSM's right to determine the size and composition of its board and corporate body has been limited, we do not think that such limitation substantially impairs any existing contractual right.

Section 301(1) states that the board shall have thirty-five directors. Article IV of BCBSM's bylaws provides that the board shall consist of forty-seven members. We fail to see how this substantially impairs the state's contract with BCBSM. Significantly, the health care industry is and always has been subject to heavy regulation. See *Blue Cross &*

Blue Shield of Michigan v Ins Comm'r, supra. See also *Energy Reserves Group, Inc v Kansas Power & Light Co, supra.* Supervision of the industry has been extensive and intrusive. Moreover, the provision in question does not divest BCBSM of any previously possessed power, nor does it impede BCBSM's ability to conduct its affairs. Nor, by the same token, has the basic structure of BCBSM or its board of directors been unreasonably altered. In this light, the mere reduction in the size of the board of directors can hardly be considered a substantial impairment.

A similar analysis is applicable to § 301(2), which authorizes the Governor to appoint four directors, and § 301(3)-(5), which requires that a certain number of directors be chosen from various enumerated groups. Again, it is significant that the health care industry has been heavily regulated. Additionally, § 301(2)-(5) is substantially the same as Article IV of BCBSM's bylaws. See also 1939 PA 108, § 8; 1939 PA 109, § 2. That article specifies a board composition much the same as that required by § 301(2)-(5).

The only real differences are that under § 301 the state is given four appointees as opposed to two under Article IV, and that § 301 mandates a slightly higher percentage of consumer representation on the board than is required under Article IV. We do not perceive either of these differences as crucial. Four appointees on a thirty-five member board as opposed to two on a forty-seven member board cannot substantially change BCBSM's ability to operate. There are still thirty-one non-public board members, who can, needless to say, override any opposition from the four public members. Hence, we find it difficult to say that BCBSM's corporate structure has been substantially altered or that the ability of the board to indepen-

dently manage BCBSM has to any significant degree been impaired.

With respect to the increase in consumer representation, we again perceive the difference as insignificant. On the old board twenty seven of forty seven directors represented consumers. On the board established under 1980 PA 350, consumers must occupy approximately twenty six of the thirty five positions. While consumer representation has been increased accordingly (in the boards under both laws, consumers are a majority), we are unable to see how this change would substantially impede BCBSM's ability to manage its affairs. By the same token, we are unable to see how such an increase substantially impairs the corporate structure of BCBSM. Although the composition of the board has been changed, the basic operation thereof has not been substantially impeded.

Section 305(1) is no more intrusive than the sections previously discussed. That section merely requires that the corporate body be twice the size of the board, that the members be selected in the same manner as the directors, and that there be eight government appointees, four of whom must be the appointed directors.

Again we must keep in mind the fact that this industry has been subject to broad and intrusive regulation. While the size of the corporate body was set at ninety three under Article I of the bylaws, twice the size of the board established under those same bylaws, we do not perceive the reduction in corporate body size to seventy to be significant for the reasons discussed in connection with the board size. Finally, we note that the state's authority to appoint eight members to the corporate body rather than the four it was empowered to appoint under Article I of the bylaws does not significantly affect the corporation's power to

govern itself and that, for the reasons discussed in connection with board appointees, we are unable to find any substantial impairment.

Even had we found that §§ 301(1)-(5), (7), and 305(1) substantially impaired BCBSM's contract with the state, we still would have upheld their constitutionality under the latter part of the balancing test. See Part II(B). To the extent that it can be argued that §§ 301(1)-(5), (7), and 305(1) impair BCBSM's contractual interests, those sections rest upon and are prompted by significant and legitimate state interests. See *Energy Reserves Group, Inc v Kansas Power & Light Co, supra.*

As noted in the preceding section in recent years BCBSM has been the subject of considerable controversy. There is evidence that BCBSM has been unresponsive to consumers' interests. Moreover, critics have charged that BCBSM has not been vigorous in its cost containment efforts.[26] The primary reason for these deficiencies is alleged to be that BCBSM has been subject to undue and excessive provider and management influence.[27] Sections 301(1)-(5), (7), and 305(1) were designed to ensure a responsive and accountable corporate membership and board, and to prevent the undue influence of certain groups.

We find these interests both legitimate and significant. BCBSM has an enormous effect on the lives of the people of this state and on the operation of the state's business, by virtue of its dominant share of the health care market.[28] Hence, its commitment, accountability, and responsiveness to the people it serves should be unwavering. In this

[26] See n 17.

[27] See Circuit Court's Finding of Relevant Facts, Nos. 3(h), (i); Defendant's Exhibit 96, "SAS" Senate Analysis Section report on House Bill 4555 (Substitute S-1).

[28] See Circuit Court's Finding of Relevant Facts, No. 3(a).

light, we hold that the state has demonstrated both a legitimate and significant interest in securing a membership and board selection and composition that is more representative of the interests to be served.

Finally, we believe that the means chosen to implement these purposes were reasonable and of a character appropriate to the legitimate public purpose noted above. See *Energy Reserves Group, Inc v Kansas Power & Light Co, supra;* see also *Van Slooten v Larsen, supra; Metropolitan Funeral System Ass'n v Ins Comm'r, supra.* The Legislature has sought to reduce the ability of providers and management to dominate BCBSM and perpetuate their position by requiring broad-based representation and limiting incumbent members' right to participate in elections. In addition, the Legislature has sought to set the framework for a more responsive BCBSM by increasing the representation of the individuals BCBSM was designed to serve, the consumers. In seeking these objectives, the Legislature has moved to provide all interested parties with an equitable opportunity to influence the selection process and subsequent managerial policies by providing for the participation of all component groups. While the predominance of management and provider groups in the corporation was the source of the perceived problem, their participation has not been eliminated, but rather reduced and more closely regulated. Thus, the state has sought to control the root of the problem and, without excluding individuals with an interest in BCBSM's operations, devise a system to ensure the representation of all interests BCBSM was designed to serve.

We thus determine that with respect to the above provisions there is not an unconstitutional

impairment of the public contract as claimed by BCBSM.

(5) *§§ 504(1), 505-513—Power of the Commissioner Over Provider Reimbursement Contracts*

BCBSM finally asserts that §§ 504(1) and 505-513 of 1980 PA 350, pertaining to regulation of provider reimbursement contracts, unconstitutionally impair its contract with the state as embodied in 1939 PA 108 and 109 by giving the Commissioner of Insurance dictatorial power over BCBSM's provider contracts and methods of provider reimbursement and by imposing vague[29] and unachievable goals upon BCBSM.

With the passage of 1980 PA 350, the Legislature sought to remedy the crisis of spiraling health care costs by establishing the following goals:

> Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:
> (a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.
> (b) Providers will meet and abide by reasonable standards of health care quality.
> (c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Pursuant to 1980 PA 350, a health care corporation, such as BCBSM, negotiates and enters into

[29] For a discussion of these sections in relation to BCBSM's vagueness challenge see Part IX.

provider class plans which must at a minimum address the access, quality, and cost goals of § 504(1). The plan is allowed to operate free of government interference for the first two years (three years, forty-five days, if the provider is reimbursed on a prospective basis, *i.e.,* hospitals), §§ 506, 509(1). If after this period of time the commissioner determines that the goals have been substantially met or that failure to satisfy any one of the goals is reasonably excused, BCBSM is permitted to negotiate new plans or continue existing plans for another two years without government involvement, §§ 509, 510. If, however, the commissioner determines the goals have not been satisfied, the commissioner's power to review and correct any deficiencies in the plan is triggered, §§ 510-513. BCBSM then has the right to appeal the commissioner's ruling to an independent hearing officer, § 515. The act provides for greater input and participation by providers and subscribers from the negotiation to the review stages of the provider class plan, §§ 505, 507, 508, 511, and 515.[30]

Under the former enabling acts, 1939 PA 108 and 109, the commissioner's continuing regulatory authority over BCBSM was limited to approving or disapproving rates for hospital services, not for physician services, according to a "fair and reasonable" standard. See *Blue Cross & Blue Shield of Michigan, supra,* pp 431-432. By contrast, 1980 PA 350 expands the commissioner's statutory authority to review rates of physician as well as hospital services and expressly delineates the factors and criteria to guide the commissioner in exercising

[30] BCBSM asserts that it cannot even begin to assess the increased regulatory and administrative expenses it will incur in order to comply with these provisions mandating provider and subscriber input procedures. However, because BCBSM is unable to substantiate this assertion by any concrete proof on the record, we reject it as too speculative.

this power. Additionally, the new act not only empowers the commissioner to approve or disapprove BCBSM's provider class plans, but also to prepare a provider class plan which meets the § 504(1) goals where the corporation fails to overcome the plan's deficiencies within a specified time. The commissioner's proposed plan will then be placed in effect unless BCBSM invokes its right to appeal the commissioner's ruling to an independent hearing officer. See § 513(2)(a). The statute further provides for judicial review of the hearing officer's decision. See §§ 501(2), 502(7), and 518.

Although 1980 PA 350 broadens and clarifies the commissioner's statutory powers from those possessed under 1939 PA 108 and 109 in the above respects, it limits the commissioner's powers in other respects. For instance, the commissioner cannot exercise these regulatory powers for two years (three years, forty-five days, for hospitals), and, if BCBSM in that time sets up a satisfactory provider reimbursement system, the commissioner has no occasion to exercise these powers at all. This is far short of the BCBSM alleged dictatorial powers of the commissioner.

In light of the above and especially given the fact that BCBSM's provider reimbursement arrangements at least as to hospital charges have always been subject to the commissioner's continuing statutory authority, we find that 1980 PA 350's broadening of the commissioner's scope of authority over provider class plans does not substantially impair BCBSM's contract with the state.

Even had we found a substantial impairment, we would nevertheless uphold these sections because they are prompted by a significant and legitimate public purpose and that the means chosen are reasonably tailored to achieve the legitimate public purpose. See Part II(B).

As previously indicated, the provider reimbursement sections of 1980 PA 350 were implemented for the primary purpose of ensuring all subscribers reasonable access to, and reasonable cost and quality of, health care services. The promotion of the health and general welfare of citizens is a matter of unquestionable state concern. See Const 1963, art 4, § 51; *W A Foote Memorial Hospital, Inc v City of Jackson Hospital Authority,* 390 Mich 193, 209-210; 211 NW2d 649 (1973), quoting from *Ecorse v Peoples Community Hospital Authority,* 336 Mich 490, 501; 58 NW2d 159 (1953); *Birth Control Centers, Inc v Reizen,* 508 F Supp 1366, 1386 (ED Mich, 1981). Hence, the purpose behind these provisions of 1980 PA 350 is both a significant and legitimate one.

Further, we believe that the means chosen to implement this public purpose are reasonable and of a character appropriate to that purpose. To support this conclusion, the circuit court found that an estimated $137 million would have been saved, a saving of approximately eight percent, if over the past four years the rate of health care costs had been capped at the rate of real economic growth multiplied by the rate of inflation as provided for in 1980 PA 350.[31] Both parties acknowledge the fact that one of the principal causes of skyrocketing health care costs is over-utilization of services. Although BCBSM does not have control over some of the factors which drive up health care costs, it does have the ability, at least in part, to reduce utilization.[32] It is widely recognized that

[31] See Circuit Court's Findings of Relevant Facts, No. 522.

[32] In the past few years, BCBSM has voluntarily implemented programs which attempt to control the utilization of health care services. Among BCBSM's cost containment programs is the replacement of the fee-for-service system, a method which in effect rewarded providers for increased utilization, with the prospective reimbursement system for hospitals' services and the Michigan Variable Fee system for

the health care system does not, and has not, operated as a competitive market. The lack of a competitive market results in less incentive to reduce costs.[33] What 1980 PA 350 attempts to do is provide greater incentives for BCBSM to use its dominant market position to engage in more effective cost containment programs.

As noted earlier, the regulatory structure of 1980 PA 350 is far short of a totally government-controlled system. Rather, it employs means which combine both free market and government intervention systems. Pursuant to 1980 PA 350, BCBSM is given the opportunity to formulate its own cost containment programs in accordance with the goals of the act. Only if BCBSM is unsuccessful in its efforts will the government step in. We find these means to be reasonable and necessary to accomplish the valid public purpose of the act.

For these reasons, we sustain 1980 PA 350's provider reimbursement regulatory scheme against the challenge on impairment of contract grounds.

D. *Conclusion as to Cumulative Effect of Challenged Sections*

Thus, having concluded that the challenged sections of 1980 PA 350, when considered separately, do not unconstitutionally impair BCBSM's existing contract with the state, we further hold that the cumulative effect of these sections does not amount to a substantial impairment of the public contract here in question.

---

physicians' services. However, the testimony and the exhibits presented are conflicting as to whether BCBSM has been successful in its efforts to control utilization. See Circuit Court's Findings of Relevant Facts, Nos. 178, 188, 192, 196, 205, 206, 216-223.

[33] See Circuit Court's Findings of Relevant Facts, Nos. 175, 176; Testimony of Professor Paul J. Feldstein, Tr Vol 12, pp 2132-2135.

With respect to §§ 202(1)(d) and 401(2), BCBSM merely misinterpreted the statute; these sections add nothing to any cumulative effect. Sections 203, 301(2)-(5), (7) and 305 relate to the corporate structure and internal affairs of BCBSM. The net practical change effected by these sections is a change in degree, rather than a change in concept. Thus, there is no drastic change in regard to BCBSM's contract with the state. Sections 205(5), 504(1), 505-513, 607 and 608 relate to the commissioner's regulation of a health care corporation's way of doing business. While 1980 PA 350 extends the area of regulation over 1939 PA 108 and 109, the cumulative effect does not take away the corporation's initiation of its own business practices, but merely empowers the commissioner to regulate a somewhat broader area. The fact is that BCBSM has been subject to past government regulation since its inception. In consideration of these factors, we find that the cumulative effect of all the sections complained of does not create a degree of impairment sufficient to be considered substantial.

Even were we to find a substantial impairment, we would still uphold 1980 PA 350 because it was enacted for a legitimate and significant public purpose, namely "to promote an appropriate distribution of health care services for all residents of this state, . . . and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state," § 102(1). Indeed, the Legislature is constitutionally mandated to adopt appropriate measures to safeguard the public health. See Const 1963, art 4, § 51.

Finally, as evidenced by our analyses with respect to the individual sections, the means adopted

by the Legislature are reasonably related to the legitimate public purpose of the act. See Part II(B).

We thus reject BCBSM's claim that the challenged sections of 1980 PA 350, as a whole, fundamentally alter BCBSM's existing contract with the state so as to violate the state or federal Contract Clause.

III. QUESTION 2

"II. DOES PA 350 DEPRIVE BCBSM OF LIBERTY AND PROPERTY WITHOUT DUE PROCESS OF LAW BY EFFECTIVELY CONVERTING A HERETOFORE PRIVATE CORPORATION INTO A PUBLIC, GOVERNMENTAL CORPORATION?"

BCBSM attacks 1980 PA 350 on the ground that certain mandatory provisions of the act, in effect, constitute a government takeover of BCBSM by transforming it from a "private" corporation into an agency of the state government in violation of due process of law.[34] The crux of BCBSM's takeover argument is that:

> By PA 350, the Michigan Legislature has charged BCBSM [A] with the responsibility for formulating and managing a health care system for the state under the superintending control of the Commissioner of Insurance. [B] It has created a legislatively mandated board of directors, with some seats guaranteed to various legislatively deter-

[34] BCBSM cites many of the same sections of 1980 PA 350 in relation to its takeover claim as it challenged under its impairment of public contract claim. Compare plaintiff's appendix, pp 441a-442a with 443a-444a. Because of this, our discussion will inevitably involve a certain amount of overlap. However, to avoid redundancy, we will refer to our previous discussion of these sections where appropriate.

In addition, nearly all the same sections BCBSM lists under its takeover argument of Question 2 are also encompassed under its due process claim of Question 5, with a few exceptions. Compare plaintiff's appendix, pp 443a-444a with 447a. In fact, Questions 2 and 5 are merely parts of the same due process challenge to 1980 PA 350.

> mined constituencies and others to political appointees. [C] It has removed from BCBSM control over its composition, structure and corporate direction. [D] It has imposed on BCBSM the governmental responsibility of ensuring for *all people in the state* access to health care benefits at a fair and reasonable cost. [E] The Commissioner of Insurance is given peremptory power and authority over the managerial affairs of BCBSM, controlling: what lines of business it writes; what kinds of certificates it writes; all charges for those certificates; BCBSM's contracts with its participating providers; and all methods of provider reimbursement. These provisions of 1980 PA 350, when considered *en masse,* amount to a governmental coup. [Emphasis in the original.]

We reject BCBSM's argument on the ground that BCBSM's construction of the act is overblown and unsubstantiated as compared with what the statute actually provides. By examining BCBSM's allegations line by line against the exact statutory language of the act, the fallacy in BCBSM's interpretation becomes clear.

[A]

After a thorough perusal of the numerous provisions of the act, we are unable to find any language, nor has BCBSM cited any, which delegates to BCBSM the responsibility for formulating and managing the state's health care system. We therefore dismiss BCBSM's first argument on the basis of our analysis under Part II(C)(1).

[B]

We find BCBSM's next allegation that 1980 PA 350's legislatively mandated board of directors has removed from BCBSM control over its board struc-

ture and composition without due process of law to be equally unfounded. BCBSM cites §§ 301(2) and 305(1), which permit the Governor to appoint members to BCBSM's governing bodies as indicia of a governmental taking. BCBSM argues that these provisions and the remaining sections of § 301 are onerous and interfere with managerial prerogatives. Hence, BCBSM concludes that there has been a taking without due process of law.

We disagree.

First we note that the mere fact that a regulation imposes a burden or expense upon the corporation, or subjects it to loss or inconvenience, does not make it a taking. See *Chesapeake & O R Co v Public Service Comm of West Virginia,* 242 US 603; 37 S Ct 234; 61 L Ed 520 (1917); *Southern Wisconsin R Co v City of Madison,* 240 US 457; 36 S Ct 400; 60 L Ed 739 (1916); *Missouri Pacific R Co v City of Omaha,* 235 US 121; 35 S Ct 82; 59 L Ed 157 (1914). We do not think that the action taken here constitutes a taking.

The state appointees constitute only a small voice on BCBSM's governing bodies, and the remainder of the requirements in no sense interfere with managerial discretion. The fact that some members and directors are required to be selected from certain groups is not so onerous as to constitute a taking. To require a membership and board of directors that is more representative of all component groups interested in BCBSM's operations does not amount to a government takeover of the corporation.

Moreover, for the very reasons discussed in Part II(C)(4), we find that §§ 301(1)-(5), (7) and 305(1) are reasonably related to a legitimate legislative objective. See *Shavers v Attorney General,* 402 Mich 554, 612-613; 267 NW2d 72 (1978). We uphold the

constitutionality of those sections as against BCBSM's due process claim.

[C]

BCBSM alleges that 1980 PA 350 has effectively removed from BCBSM control over its corporate direction. Specifically, BCBSM argues that by stripping its corporate members of the power and authority they formerly had to amend, adopt or repeal the bylaws and placing this power in the board of directors, § 302(1) of 1980 PA 350 constitutes a taking of BCBSM's property without due process of law.

We disagree.

Contrary to BCBSM's contention, the act does not remove control from BCBSM over its corporate direction, but instead shifts it from BCBSM's corporate members to its board of directors. While in some sense this can be deemed a loss of the members' unqualified right to control the corporation, it is clear that losses incident to the lawful exercise of the police power are noncompensable. See Nowak, Rotunda & Young, Constitutional Law (2d ed), pp 483-485; Sax, *Takings and the police power,* 74 Yale L J 36 (1964). The United States Supreme Court has consistently upheld government regulation which may result in the loss of use or economic exploitation of property of a private owner without requiring compensation where such regulation was justified as promoting the health, safety, morals or general welfare of the public. See *Andrus v Allard,* 444 US 51, 64-68; 100 S Ct 318; 62 L Ed 2d 210 (1979); *Penn Central Transportation Co v New York City,* 438 US 104, 123-129; 98 S Ct 2646; 57 L Ed 2d 631 (1978).

In *Penn Central, supra,* p 124, the Court identified several factors to determine when a regulatory

measure rises to a "taking" in violation of the Fifth Amendment:

> The economic impact of the regulation on the claimant and, particularly, the extent to which the regulation has interfered with distinct investment-backed expectations are, of course, relevant considerations. So, too, is the character of the governmental action. A "taking" may more readily be found when the interference with property can be characterized as a physical invasion by government, than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good. [Citations omitted.]

Under the circumstances in the instant case, the regulation in question does not amount to a "taking." The members of BCBSM, unlike stockholders of a corporation, have no "investment-backed expectations" in their unqualified right to control BCBSM. BCBSM points to no discernible monetary or other equitable interest of the members in BCBSM, which give rise to an investment-backed expectation. While several hospitals and the Michigan Medical Society did advance money for working capital for the predecessors of BCBSM, this money was advanced in the form of a loan and it seems has in fact been repaid. Further, the regulation cannot be characterized as a "physical invasion by government" over BCBSM's corporate direction. The purpose of this provision transferring control over BCBSM's bylaws from the members to the directors is to promote the interests of all component groups BCBSM was designed to serve and to reduce the possibility of any one group gaining unassailable dominance over the corporation. We fail to see how this provision constitutes a governmental "taking" of BCBSM's property.

[D]

BCBSM's fourth allegation that the act burdens it with the duty to ensure access to health care benefits at a fair and reasonable cost for all people of the state is another example of BCBSM's misinterpretation of the applicable statutory language. A proper interpretation of the act indicates that the Legislature intended BCBSM to secure the opportunity for access to health care services at a fair and reasonable price "for all of the people of this state *who apply for a certificate,*" § 202(1)(d)(ii). We are unable to discern how this provision imposes upon BCBSM an exclusively governmental function. See Part II(C)(1).

[E]

We also reject BCBSM's final allegation that 1980 PA 350 gives the Insurance Commissioner peremptory power over the managerial affairs of BCBSM with respect to what lines of business it writes, types of and rates for subscriber certificates, participating provider contracts and methods of provider reimbursement. Again, BCBSM presents a distorted view of the actual statutory provisions. Under our interpretation of the act, BCBSM's managerial power over its lines of business, subscriber certificates, and provider reimbursement contracts has not been preempted by the Insurance Commissioner. BCBSM still has the power to establish its lines of business, § 205(4), to establish and set rates for subscriber certificates, § 607(1), to enter into provider class plans, § 502(1), and to formulate its methods of provider reimbursement in accordance with the "access," "quality," and "cost" goals of the act, § 504(1). The Insurance Commissioner's

authority under 1980 PA 350 with respect to the affairs of BCBSM is regulatory not peremptory.[35]

We note that under 1939 PA 108 and 109, the commissioner exercised regulatory power over issuance of subscriber certificates, 1939 PA 108, § 5, 1939 PA 109, § 6, rates of those certificates, 1939 PA 109, § 3, and hospital reimbursement arrangements, 1939 PA 109, § 3. See generally *Blue Cross & Blue Shield of Michigan, supra.* Moreover, regulatory power was also exercised over lines of business.[36] While in certain respects the commissioner's regulatory powers over BCBSM have been broadened and clarified under 1980 PA 350,[37] they are for all intents and purposes coextensive with those the commissioner previously possessed under 1939 PA 108 and 109. Management of the corporation, however, continues to be entrusted to BCBSM's board of directors, subject as always to the regulatory authority of the Insurance Commissioner. See § 301(1); see also *Blue Cross & Blue Shield of Michigan, supra,* p 429.

Thus, we find BCBSM's claim that the challenged provisions of 1980 PA 350, in whole or in part, constitute a takeover of BCBSM by transforming it from a "private" corporation into a government entity without due process of law to be completely unsound.

IV. QUESTION 3

"III. DOES PA 350 CONSTITUTE AN UNCONSTITUTIONAL DELEGATION OF LEGISLATIVE AUTHORITY TO BCBSM AND OTHER PRIVATE PERSONS?"

---

[35] For the commissioner's statutory authority with respect to a health care corporation's lines of business, see § 205(5); rates of subscriber certificates, see § 607(3); provider class plans, see §§ 509-513.

[36] See n 24.

[37] See n 35.

BCBSM further challenges 1980 PA 350 as an unconstitutional attempt by the Legislature to delegate legislative power to BCBSM and private individuals. BCBSM claims that three areas in the statute permit such a delegation: the alleged directive to BCBSM to establish a statewide health care financing system, the creation of a panel of three actuaries to resolve risk factor disputes, and the appointment of independent hearing officers to settle rate challenges. We find only § 205(6), which establishes the actuary panel, to be constitutionally infirm.

A. *Statewide Health Care Financing System*

As a threshold matter, BCBSM asserts that the essential purpose of the statute is to thrust upon BCBSM the "legislative task of formulating a health care finance system for *all* persons in the State of Michigan." BCBSM argues that the policy formulation entailed in the establishment of a statewide health care financing program may not be delegated to a private corporation.[38]

However, we may speedily dispose of this delegation challenge for the simple reason that the statute makes no attempt to establish a statewide health program, much less delegate the development and administration of the program to BCBSM. See Part II(C)(1).

---

[38] As evidence of this delegation, BCBSM primarily relies on § 202(1)(d)(*iii*) which directs a health care corporation to include in its articles of incorporation a provision assuring all subscribers "reasonable access to, and reasonable cost and quality of, health care services."

BCBSM also alludes to many of part 5 of the act's provisions regarding contracts between BCBSM and health care facilities and professionals. However, these sections' references to reasonable cost, quality and access have no bearing on the creation *vel non* of a health care system to encompass the entire state. The articulated goals only apply to BCBSM's relationship with its subscribers.

B. *Actuary Panel—§ 205(6)*

BCBSM next challenges § 205(6), which establishes a panel of three actuaries to resolve risk factor disputes. BCBSM charges that § 205(6) is an unconstitutional delegation of legislative authority in that it lacks adequate standards to guide the panel's action.[39]

Challenges of unconstitutional delegation of legislative power are generally framed in terms of the adequacy of the standards fashioned by the Legislature to channel the agency's or individual's exercise of the delegated power. See, *e.g., Osius v St Clair Shores,* 344 Mich 693, 698; 75 NW2d 25 (1956). Although for many years this and other courts evaluated delegation challenges in terms of whether a legislative (policymaking) or administrative (factfinding) function was the subject of the delegation, this analysis was replaced by the "standards" test as it became apparent that the essential purpose of the delegation doctrine was to protect the public from misuses of the delegated power. The Court reasoned that if sufficient standards and safeguards directed and checked the exercise of delegated power, the Legislature could safely avail itself of the resources and expertise of agencies and individuals to assist the formulation and execution of legislative policy.

The criteria this Court has utilized in evaluating legislative standards are set forth in *Dep't of Natural Resources v Seaman,* 396 Mich 299, 309; 240 NW2d 206 (1976): 1) the act must be read as a whole; 2) the act carries a presumption of constitutionality; and 3) the standards must be as reasonably precise as the subject matter requires or

[39] BCBSM further alleges that § 205(6) delegates legislative policymaking power to unaccountable private persons. However, our analysis of the standard's challenge obviates the need to address BCBSM's accountability argument.

permits. The preciseness required of the standards will depend on the complexity of the subject. *Argo Oil Corp v Atwood,* 274 Mich 47, 53; 264 NW 285 (1935). Additionally, due process requirements must be satisfied for the statute to pass constitutional muster. *State Highway Comm v Vanderkloot,* 392 Mich 159, 174; 220 NW2d 416 (1974). Using these guidelines, the Court evaluates the statute's safeguards to insure against excessive delegation and misuse of delegated power.

BCBSM complains that § 205(6) contains "absolutely no standards" to guide the actuaries in their determination of risk factors. We generally agree.

(1) *The Statute*

"Risk factor" is defined in § 205(13)(c) as "the relative probability of loss associated with a given line of business, expressed as a percentage of incurred claims and incurred expenses for a calendar year." Sections 205(4), (5) and (6) establish a three-part procedure to formulate risk factors.

First, the health care corporation must assign a risk factor for each line of the corporation's business. Section 205(4) directs that the risk factor "shall be established in accordance with sound actuarial practices. . . ."

Second, the Insurance Commissioner must either "approve" or "disapprove" the factors proposed by the health care corporation, § 205(5). No guidelines are provided to direct the Insurance Commissioner's response.[40]

Third, if the risk factors are disapproved, a

[40] Section 205(5) provides:

"Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

"(a) Approve the factors and proceed under subsection (7).

"(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. . . .

"(c) Disapprove the factors, and proceed under subsection (6)."

panel of three actuaries "shall determine a risk factor for each line of business," § 205(6). No further directions are set forth to guide the panel.

The act provides no administrative or judicial review to challenge either the Insurance Commissioner's or the actuary panel's decision.

(2) *Adequacy of the Standards*

In order to properly evaluate BCBSM's contention that the act provides "absolutely no standards to guide these ad hoc actuaries," each of the interrelated procedures must be examined.

The only direction given to the health care corporations is that "sound actuarial practices" shall be used. Yet this apparently broad, general directive in fact invokes a body of guidelines.

Determination of risk factors is an integral part of actuarial science. Guidelines to standardize this statistical determination are published by the society of actuaries and the casualty actuarial society. Of course, determination of risk factors is not a mechanical calculation; there is no *one* correct risk factor because there is no *one* correct actuarially sound method of computation. See Beard, Pentikainen & Pesonen, *Risk Theory* (London: Methuen & Co Ltd., 1969); *cf. Kosa v State Treasurer,* 408 Mich 356, 372-373; 292 NW2d 452 (1980). Nonetheless, given the technical nature of actuarial science and the body of guidelines promulgated by the professional associations, the section provides a set of concrete standards to guide and constrain the health care corporations' actions.

In contrast, the power delegated to the Insurance Commissioner is completely open-ended. The commissioner is starkly directed to "approve" or "disapprove" the proposed risk factors; the basis of the evaluation is not addressed. In fact, it is impossible to determine even the nature of the Insur-

ance Commissioner's inquiry—whether the commissioner is deciding (1) that the health care corporation's proposed risk factors are actuarially sound, or (2) that, although the proposed factors are actuarially sound, a different set of actuarially sound risk factors are preferred by the commissioner.[41]

This ambiguity is central to the dispute; the nature of the inquiry considerably alters the standards required to prevent an abuse of discretion. For instance, if the Insurance Commissioner merely reviews the proposed factors to insure that they are in accordance with sound actuarial practices, it is unlikely that any further standard is required. If, however, the Insurance Commissioner may reject actuarially sound risk factors proposed by the health care corporation simply because of a preference for alternate risk factors, some criteria must be included to guide the Insurance Commissioner's preference of one risk factor over another. Without additional standards, the Insurance Commissioner has de facto veto power over the health care corporation's risk factors. This lack of clarity regarding the Insurance Commissioner's function permits the Insurance Commissioner to define the authority of the commissioner. Finally, the ambiguous nature of the Insurance Commissioner's inquiry affects the function of the actuary panel. If the commissioner's power is confined to vetoing actuarially unsound risk factors, the directive to the panel to establish actuarially sound risk factors, without more, may sufficiently tailor the

[41] We note that the requirement of actuarially sound practices is not included in § 205(5). However, a reasonable reading of the act as a whole warrants the incorporation of the requirement. It is unrealistic to expect the Legislature to require actuarially sound risk factors of the health care corporation, but to omit this practical, and fiscally sound, requirement with regards to the Insurance Commissioner and the actuary panel.

panel's inquiry to pass constitutional muster. On the other hand, it is equally plausible to read the panel's function as an arbitration procedure: the panel must choose between the factors proposed by the corporation and the Insurance Commissioner, or reject both and choose a third risk factor. If this is the function delegated to the panel, the standards provided are wholly inadequate. The act is completely devoid of any indication why one factor should be preferred over another; no underlying policy has been articulated, nor has the Legislature detailed the criteria to be employed by the panel in making this determination.[42] This complete lack of standards is constitutionally impermissible. *Osius v St Clair Shores, supra.*

Thus, the lack of standards defining and directing the Insurance Commissioner's and the actuary panel's authority renders this dispute resolution mechanism constitutionally defective.

C. *Hearing Officers—§§ 514 and 613*

Finally, BCBSM argues that the Legislature unconstitutionally delegated authority to the hearing officers who resolve part 5 rate disputes, § 514, and rate filing disputes, § 613, because they are "wholly unaccountable to anyone." We disagree.

(1) *§ 514*

Very briefly, § 514 provides that all appeals under part 5 of the act (which deals with contracts between the health care corporation and health care facilities and professionals) shall be held before an independent hearing officer. The appeals may be brought to review various actions or determinations of the Insurance Commissioner.

The selection of the hearing officers is quite

[42] Nor does the defendant offer any suggestion. In fact, defendant agreed at one hearing that the section was unconstitutional.

detailed. Section 514 directs the State Court Administrator to compile a list of possible officers who meet certain qualifications: the hearing officer must be a retired circuit court judge, a Michigan resident not involved in the provision of health care services and not an employee or officer of a health care provider or health care corporation or an employee of the state. The hearing officers are randomly selected from the compiled list by the Insurance Commissioner; they serve per appeal.

BCBSM articulates its challenge to the section:

> Basic determinations with respect to provider class plans, which control BCBSM's contracts and reimbursement arrangements with health care providers, are placed in the hands of hit and run "independent hearing officers" (§ 514) who are again wholly unaccountable to anyone, who are not members of any public body, and who are not removable by any public representative.

We must disagree with BCBSM's claim. The hearing officers' fidelity to the statutory role assigned them is monitored in several ways. First, § 514(4) requires the Insurance Commissioner to report to the appropriate legislative standing committees information on the hearing officers' performance. The data include: the number of appeals heard; the nature of the controversy; the disposition of the appeal; the existence of a judicial appeal, and its result. One may safely assume that the legislative committee will review this information and alter the statute if the hearing officers do not act in conformity with the statute.

Second, the list of possible hearing officers is compiled by the State Court Administrator, a person appointed by and thus responsible to the Supreme Court, an elected body. One may assume that the State Court Administrator will thus care-

fully select the hearing officer candidates and attentively monitor their performance. Also, contrary to BCBSM's contention, the individuals may be removed from the list of potential hearing officers at the discretion of the State Court Administrator.

Third, the hearing officers' decisions are not immune from challenge. The statute specifically provides for judicial review of the hearing officers' decisions, §§ 501(2), 502(7). Section 518 provides:

> An appeal from a final determination of an independent hearing officer shall be conducted pursuant to chapter 6 of the administrative procedures act, except that the appeal shall be taken within 30 days after the final determination, upon leave granted, in the court of appeals.

Chapter 6 of the Administrative Procedures Act, MCL 24.301-24.306; MSA 3.560(201)-3.560(206), sets forth the procedures to be followed for direct review by the courts of an administrative decision. The court's standard of review is carefully delineated:

> (1) Except when a statute or the constitution provides for a different scope of review, the court shall hold unlawful and set aside a decision or order of an agency if substantial rights of the petitioner have been prejudiced because the decision or order is any of the following:
> (a) In violation of the constitution or a statute.
> (b) In excess of the statutory authority or jurisdiction of the agency.
> (c) Made upon unlawful procedure resulting in material prejudice to a party.
> (d) Not supported by competent, material and substantial evidence on the whole record.
> (e) Arbitrary, capricious or clearly an abuse or unwarranted exercise of discretion.

(f) Affected by other substantial and material error of law. [MCL 24.306; MSA 3.506(206).]

This provision ensures that the reviewing court has broad enough authority to rectify a decision of a hearing officer which is repugnant to or in contravention of the statute.

This avenue of judicial review, in conjunction with the Legislature's express intent to review the hearing officers' performance and the State Court Administrator's interest in recommending only qualified individuals, contradicts BCBSM's assertion that the hearing officers are "wholly unaccountable"; the hearing officers' decisions will be measured against the statutory requirements to ensure against abuse of the delegated authority.

(2) *§ 613*

Finally, BCBSM focuses on § 613 which provides for independent hearing officers to conduct hearings between the health care corporation and the requesting party on whether proposed rate filings meet the requirements of the act. Again, BCBSM alleges that the independent hearing officers are wholly unaccountable. We disagree.

Section 613(1) directs that the independent hearing officer shall be appointed by the Insurance Commissioner, an appointee of the Governor with the consent of the Senate. MCL 500.202; MSA 24.1202. The individual appointee must meet certain criteria:

In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person

selected shall not be currently or actively employed by this state.

The independent hearing officer must conduct the hearing according to the Administrative Procedures Act, § 613(2). Within thirty days after receipt of the hearing officer's proposed decision, the Insurance Commissioner shall render a decision which includes a statement of findings, § 613(4). The commissioner's decision may be reviewed directly by the courts, § 615. Thus, the hearing officers' decisions are filtered through the politically and judicially accountable Insurance Commissioner. This procedure provides sufficient checks on the delegation of legislative power. The Legislature has included adequate safeguards to restrain the hearing officers from abusing or misusing the delegated power.

V. QUESTION 4

"IV. DO SECTIONS 203, 206(4), 211, 301(7), 302(1), 305(1), 509(4)(b), 510 AND/OR 516(2)(b) OF PA 350 UNCONSTITUTIONALLY IMPAIR PRIVATE, VESTED CONTRACT RIGHTS BETWEEN BCBSM AND ITS MEMBERS, PARTICIPATING PROVIDERS AND CUSTOMERS?"[43]

BCBSM also contends that certain sections of 1980 PA 350 unconstitutionally impair the private contract rights between BCBSM and its corporate members, its subscribers, and providers.

We note that the test stated in Part II(B), for

[43] We note that BCBSM's use of the phrase "and/or" in this certified question and the succeeding questions 6 through 8, Parts VII-IX, does not necessarily require us to address the cumulative effect of the particular sections challenged as to each question since BCBSM does not specifically argue this point in its brief. Rather, we take this phrase to mean that some or all of the challenged sections may be unconstitutional but we need not consider whether cumulatively they are constitutionally infirm. Only with respect to questions 1 and 2, Parts II and III, does BCBSM make this cumulative effect argument in its brief.

analyzing BCBSM's impairment of public contract claim is equally applicable for adjudicating this impairment of private contract challenge. See *United States Trust Co v New Jersey*, 431 US 1, 25-26; 47 S Ct 1505; 52 L Ed 2d 92 (1977).

A. *§§ 203, 302(1)*

BCBSM argues that § 203, which places the *power to amend the restated articles of incorporation in the board of directors,* impairs the corporate members' contract with the state and corporation as embodied in 1939 PA 108 and 109 and the restated articles of incorporation. Under 1939 PA 108, § 4, 1939 PA 109, § 5 and Article VIII of the restated articles of incorporation, the corporate members are empowered *to amend the restated articles of incorporation.* BCBSM contends that this shifting of authority from the corporate membership to the board of directors operates to impair the members' contract with BCBSM and the state.

BCBSM similarly argues that § 302(1), which places the *power to adopt, repeal and amend the bylaws in the board of directors,* violates the members' contract with the state and corporation as embodied in the restated articles of incorporation and the bylaws. Article VII of the restated articles empowers the board of directors to adopt, amend and repeal the bylaws as provided therein. Article IX of the bylaws states that the board has such power except as to *Articles I, II, IV and IX of the bylaws which can only be amended or repealed by the corporate members.* Consequently, BCBSM contends that as to those articles this shifting of authority from the corporate members to the board divests the former of their previously held authority and thereby impairs the corporate members' contract with the state and corporation.

In scrutinizing Contract Clause claims under the state and federal constitutions, our first inquiry is whether the enactment operates to substantially impair a contractual relationship. Second, in determining the severity of the impairment, a critical factor is whether the industry has been regulated in the past. Third, if the impairment is minimal, our inquiry ends. Fourth, if, however, we find a substantial impairment, we must ascertain, (a) whether there is a significant and legitimate public purpose behind the regulation and, (b) if so, whether the means adopted are reasonably related to the public purpose. See *Energy Reserves Group, Inc v Kansas Power & Light Co, supra,* 74 L Ed 2d 580-581. See also Part II(B).[44]

As to whether §§ 203 and 302(1) *substantially* impair the members' contract with the state and the corporation, we are not convinced that they do. We acknowledge that the corporate members have been divested of the direct power they formerly held to alter the articles and bylaws, and that this is a considerable impairment. Nevertheless, we are unpersuaded that this impairment is substantial where the industry has been state regulated.

It is a fact that BCBSM is and always has been subject to regulation by the commissioner and Attorney General over its articles and bylaws. See 1939 PA 108 §§ 3-5; 1939 PA 109 §§ 4-6. This regulation has been extensive and intrusive. The members of BCBSM became members with the knowledge that BCBSM has been so regulated. We thus find it difficult to qualify the impairment here as substantial.

Even had we found that §§ 203 and 302(1) operated to substantially impair the corporate mem-

[44] We do not consider for purposes of determining whether there is a case or controversy the fact that the corporate members as such are not a party to this suit.

bers' contract with BCBSM and the state, we still would have upheld their constitutionality under 4(a) and (b) of our test. To whatever extent §§ 203 and 302(1) impair the corporate members' contractual interests, the impairment created by those sections rests upon and is prompted by significant and legitimate state interests.

As previously noted in Part II(C)(4), in recent years BCBSM has been the subject of considerable controversy. The evidence indicates that BCBSM has been unresponsive to consumers' interests. In addition, critics have charged that BCBSM has not been vigorous in its cost containment efforts. The main reason alleged for these deficiencies is that BCBSM has been subject to undue and excessive provider and management influence. Allegedly, management and provider influence has been primarily fortified in the corporate membership.

The corporate membership under 1939 PA 108 and 109 elects not only the board of directors, but new corporate members as well. See BCBSM's Restated Articles of Incorporation, Articles IV and V; BCBSM's Bylaws, Articles I and IV. By thus gaining control of the corporate membership, the providers and management have allegedly been able to improperly perpetuate their positions and effectively control BCBSM in derogation of other interests. Since the power to elect the corporate body and board is derived from the restated articles of incorporation and Articles I and IV of the bylaws, which only the corporate members have the authority to alter, no one has been able to overcome the influence of the providers and management. Sections 203 and 302(1) indicate, first, a legislative determination that it is unwise to vest one body with such control over elections and the power to alter the bylaws and articles and, second, a legislative purpose to change that.

We find that the legislative purpose is both legitimate and significant. Sections 203 and 302(1) operate to reduce the possibility that any one group will dominate BCBSM in the future. Thus, they help to ensure the fair and equitable control of BCBSM by all interested parties. In this light, we hold that the state has demonstrated both a legitimate and significant purpose.

Finally, we believe that the means of implementation chosen were reasonable and of a character appropriate to the legitimate public purpose noted above. The Legislature has sought to reduce the ability of any one group to dominate and control BCBSM. Past experience is said to have shown that one group has been able to accomplish such domination because it was able to gain control of the corporate membership which possessed monopoly power over elections and the right to amend the bylaws and articles. The Legislature has eliminated the corporate membership's sole power to amend the bylaws and articles and has thereby reduced the opportunity for any one group to control BCBSM. Even if one group were able to again obtain control over the corporate membership, they would be unable to control BCBSM since any authority they possessed could be held in check by the board of directors' power to amend the bylaws and articles. However, we point out that the Legislature has not removed all of the corporate members' previously held authority, but merely the right to amend the articles and bylaws. Thus, we think that the means chosen to implement the legitimate governmental purpose are reasonable and of a character appropriate to that purpose.

We thus determine that with respect to the above provisions there is not an unconstitutional impairment of contract as claimed by BCBSM.

B. *§§ 301(7), 305(1)*

BCBSM asserts that the restated articles of incorporation and the bylaws endowed the corporate membership *with the authority to select* BCBSM's *corporate membership and board of directors.* See BCBSM's Restated Articles of Incorporation, Articles IV and V; BCBSM's Bylaws, Articles I and IV. BCBSM further asserts that the articles of incorporation and the bylaws confer those rights upon the *corporate members* as a contractual right which the state has substantially impaired through the enactment of §§ 301(7) and 305(1).[45]

Section 301(7) restricts the right of the incumbent board of directors, corporate membership, management and members of each, to participate as such in the board of directors' selection, allowing participation only to the extent that the individual is a subscriber or to the extent that participation does not involve nomination, endorsement, approval or confirmation of a candidate or director. Section 305(1) declares that the non-public corporate membership shall be selected in the same fashion as the non-public members of the board as set forth in § 301.

Section 301 establishes the size and composition of the board of directors and provides that the method of selection shall be specified in BCBSM's bylaws. In addition to the foregoing, § 305(1) states that there shall be two non-public members for each non-public director. As to the public members, the four appointed directors under § 301(2) are also public members, and the Governor is authorized to appoint four additional public members, making a total of eight gubernatorially appointed public members.

Again, the first inquiry here is whether §§ 301(7)

[45] BCBSM does not make this argument with respect to § 301(1)-(5).

and 305(1) substantially impair the members' contractual relationship with BCBSM and the state.

With respect to § 305(1), we recognize that it has in effect dispossessed the members of the *sole authority* they previously held to determine the method of selecting BCBSM's corporate membership since under 1980 PA 350 the method of selection is to be specified in the bylaws which are now in the control of the directors. As noted in the preceding section, BCBSM's bylaws have always been subject to extensive state regulation. The members acquired their positions with knowledge of this state regulation. In this light, we do not, therefore, find that this impairment of the members' direct power to control the method of selection to be substantial.

Another aspect of § 305(1) which could in any sense be labeled an impairment of the corporate members' right to select the corporate body is that portion which authorizes the appointment of eight public members, instead of four under the current system. The difference, however, between the number of appointments formerly authorized and the number now authorized is only four. The corporate body consists of seventy members. See 1980 PA 350, §§ 301(1) and 305(1). We again note that BCBSM has always been subject to broad and intrusive regulation. The members joined BCBSM with this knowledge. We therefore deem the impairment, if any, unsubstantial. In fact, we deem this conclusion so manifest that we need not address the question whether the state has a legitimate purpose and has employed means both reasonable and of a character appropriate to that purpose.

With respect to § 301(7), which limits participation of corporate members, board members, and management in the selection, we are again unpersuaded that a substantial impairment exists. Sec-

tion 301(7) specifically exempts from its ambit of participation in the election the officer or employee of BCBSM who is authorized to serve as a member of the board of directors. See 1980 PA 350, § 301(4). In addition, the corporate members in their capacity as subscribers are permitted to participate in the election to the same extent as any other subscriber. As a matter of fact, corporate members are permitted to participate in the election in any capacity other than as one of the enumerated corporate officials. Finally, we note that even the proscription against participation by members only applies to the "nomination, endorsement, approval, or confirmation of a candidate or director." See Part X. In view of these limitations, and the fact that the members joined BCBSM with the knowledge that BCBSM has always been subject to broad and intrusive regulation, we are not convinced of the existence of a substantial impairment.

Nevertheless, even if we were convinced that a substantial impairment existed, we would still have upheld the constitutionality of § 301(7) under 4(a) and (b) of our test.

As to 4(a), to the degree that it can be argued that § 301(7) substantially impairs the members' contractual interests, that section rests upon and is prompted by significant and legitimate state interests. The corporate members of BCBSM are in a powerful position with regard to board elections. They are in a position to sway the election through the use of their corporate titles and the corporate facilities and resources. In an election, the mode of use typically takes the form of endorsement, nomination, approval or confirmation. In this way corporate members may manipulate the election of a particular candidate, and in return acquire political debts from candidates who

are aided by the members' support. This tends to directly undermine the integrity of the election, and the responsibility of all those concerned for the successful functioning of that process. We think that the state's interest in preventing this possibility mandates a finding that § 301(7) rests upon and is prompted by a significant and legitimate state interest. See Part X.

Lastly, we find that the means chosen to implement these purposes were reasonable and of a character appropriate to the legitimate public purpose noted above. The Legislature perceived the problem to be the potential for misuse of the corporate members' position as corporate members in the election. This potential emanated from the position of corporate members as corporate members combined with their active participation in the election. The Legislature has curtailed the members', as corporate members (instead of as subscribers), ability to actively campaign in those elections, which should reduce the possibility that corporate titles, facilities, and resources will be used to ensure the election of any particular candidate. In employing these reasonable means to achieve its legitimate purpose, however, the state has not unduly restricted the rights of the corporate members. As previously noted, the right of the corporate members to participate in the election has merely been curtailed, not eliminated. Hence, we hold that the means chosen to implement the legitimate governmental purposes are both reasonable and of a character appropriate to that purpose.

We reject BCBSM's claim.

C. *§ 206(4)*

BCBSM assails § 206(4), which prohibits health

care corporations from transacting or marketing insurance in addition to delivering health care, on the ground that it substantially impairs its contractual relationships with those to whom BCBSM has issued insurance.

In the 1950s, BCBSM began to market insurance with its health care services. This was primarily accomplished by having an agent from an insurance company call on BCBSM's customers with BCBSM's agents to present a complete package.[46] In the face of an increased demand, in the early 1960s BCBSM entered into an informal agreement with Phoenix Mutual Insurance Company whereby the latter's agents would accompany BCBSM's sales representatives to present individual proposals at the same time. By the late 1970s, the arrangement with Phoenix was proving insufficient to meet market demands.[47]

The inability to satisfy market demands led to a series of events that eventually culminated in an arrangement between BCBSM and American Bankers Life Assurance Company (ABL), whereby BCBSM's sales representatives became licensed agents to sell ABL insurance in conjunction with BCBSM coverage. Subsequently, in the spring of 1981, BCBSM's subsidiary acquired a fifty percent interest in Associated Insurance Agency, an existing insurance agency. Associated licensed BCBSM's sales representative to sell the insurance of ABL or other companies in conjunction with BCBSM's health care coverage. The underwriting company or ABL pays standard agency commissions to Associated, which in turn pays agent commissions to BCBSM sales representatives. Apparently, it was

[46] "Packaging refers to an arrangement whereby a subscriber group purchases related lines of insurance, such as group life insurance, from a single representative." See Circuit Court's Findings of Relevant Facts, No. 301.

[47] See Circuit Court's Findings of Relevant Facts, Nos. 311-313.

felt that it would be more economical for ABL to pay a standard commission to Associated rather than maintain a branch office in Michigan. All insurance premiums are paid directly to the insurance company and the company likewise directly underwrites and processes claims. Presently, BCBSM sales representatives who are licensed by the state to engage in the marketing of insurance are authorized to sell group life, accidental death and dismemberment, short- and long-term disability, dependent life, and travel accident insurance along with BCBSM health care coverage.[48]

BCBSM points out that it currently has 973 groups on a packaged arrangement, whereby BCBSM services the health care, and Associated services insurance. BCBSM contends that § 206(4)'s prohibition against such arrangements will substantially impair its existing 973 packaging arrangements by extinguishing them. BCBSM concludes that § 206(4) must be struck down as violative of the Contract Clause.

We disagree.

The health care industry in Michigan has been heavily regulated from its inception. In fact, BCBSM has operated under 1939 PA 108 and 109, which extensively controlled BCBSM's operations from its inception. Those acts specifically proscribe the execution of a contract, by or on behalf of a health care corporation, which provides "for the payment of cash or other material benefit by that corporation to the subscriber or his or her estate on account of death, illness, or injury, . . . *[or is] in any way related to the payment of a benefit by any other agency,*" 1939 PA 108, § 2(1); 1939 PA 109, § 11 (emphasis added). See 1939 PA 108, § 3; 1939 PA 109, §§ 1, 4.

[48] See Circuit Court's Findings of Relevant Facts, Nos. 313-338.

Clearly, the above provisions from 1939 PA 108 and 109 expressly prohibit BCBSM's actions here. It is axiomatic that "[o]ne whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them." *Energy Reserves Group, Inc v Kansas Power & Light Co, supra,* p 580, quoting from *Hudson Water Co v McCarter,* 209 US 349, 357; 28 S Ct 529; 52 L Ed 828 (1908). BCBSM never had the right to enter packaging contractual obligations, and thus there can be no impairment of contract as to these illegal contracts.

We express no opinion as to the availability or form of relief which may be sought by the 973 groups currently operating under such illegal packaged arrangements. However, we order the trial court on remand to require BCBSM to give each of these groups prompt and adequate notice that such arrangements were entered into without authority.

D. *§ 211*

BCBSM attacks § 211, which restricts BCBSM's power to enter into administrative services only contracts (ASO), on several grounds. In addition to BCBSM's claim that this section substantially impairs BCBSM's private contractual relationships with its ASO customers, BCBSM claims that it violates due process and equal protection. Because we find this provision violates BCBSM's right to equal protection of law, see Part VII(A), we need not address BCBSM's impairment of private contract claim.

E. *§§ 509(4)(b), 516(2)(b), 510*

BCBSM claims that §§ 509(4)(b), 516(2)(b), and

510[49] impair existing private contracts between BCBSM and its participating providers by vesting in the Insurance Commissioner the power to determine the share of provider reimbursement costs BCBSM must pay its providers. We quote from BCBSM's reply brief, wherein it states that:

> BCBSM makes no esoteric claim of right to contract with providers free from appropriate governmental oversight. The fact is, however, that BCBSM has *existing* participating contracts with providers which cannot be willy-nilly impaired by either the Legislature *or* the Commissioner of Insurance. Settled authority establishes that vesting the power to annul these contracts in the commissioner impairs the contractual rights of BCBSM *vis-à-vis* participating providers.

---

[49] Section 509(4)(b) provides, in pertinent part:

"The commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporation's fair share of reasonable costs to the provider are borne by other health care purchasers."

Section 516(2)(b), the hospital costs counterpart of § 509(4)(b), provides:

"(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives."

Section 510 sets forth the commissioner's review power, which by reference includes consideration of the above two provisions, and states, in relevant part:

"(1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall determined *[sic]* 1 of the following:

"(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

"(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

"(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504."

It is clear from this language that BCBSM is contesting the Insurance Commissioner's power under §§ 509(4)(b), 516(2)(b) and 510 of 1980 PA 350 only in relation to existing provider contracts at the time the act goes into effect and not to any future contracts BCBSM may enter into after that date. The act, however, specifically provides that "a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act" is to continue in effect for a period of two years (three years and forty-five days if the provider is reimbursed on a prospective basis) before the commissioner may exercise authority under the challenged sections of the act. See § 509(1)(a).

Therefore, in order for BCBSM to prevail on its impairment of private contract claim as to the provisions in question, we would have to assume that BCBSM's existing provider contracts will not expire nor be modified within the grace period. The possibility of this occurring is highly remote and too speculative. Because the circumstances of the contracting parties may change before the commissioner is authorized to invoke any powers under 1980 PA 350, there is at the present time no actual controversy as to BCBSM's impairment of contract claim. We therefore decline to address this constitutional issue given its basis upon an entirely speculative and remote situation. GCR 1963, 797.1(a). See *Shavers v Attorney General, supra,* 402 Mich 589; *Merkel v Long,* 368 Mich 1, 13; 117 NW2d 130 (1962).[50]

---

[50] This case is before the Court as certified questions from a declaratory judgment action. The certified question rule, GCR 1963, 797.1, requires "a pending case or controversy." The declaratory judgment rule, GCR 1963, 521.1, requires "a case of actual controversy." The cases applying these standards treat the terms similarly. See *Foote Memorial Hospital v Jackson Hospital Authority,* 390 Mich 193, 228-233; 211 NW2d 649 (1973) (LEVIN, J., *dissenting in part and concur-*

VI. QUESTION 5

"V. DO SECTIONS 104(3), 206(4), 211, 217, 401(7), 414a, 415, 502(1)(b) AND/OR 607(1) OF PA 350 DEPRIVE BCBSM OF LIBERTY AND PROPERTY WITHOUT DUE PROCESS OF LAW BY REGULATING BCBSM IN AN ARBITRARY AND DISCRIMINATORY MANNER WHICH BEARS NO REAL AND SUBSTANTIAL RELATIONSHIP TO THE OBJECTS OF PA 350 OR TO THE GENERAL HEALTH AND WELFARE OF THE PEOPLE OF THIS STATE?"

As with BCBSM's impairment of contract challenge, the central issue underlying its due process challenge is whether the legislation represents a valid exercise of the state's police power. It has been long recognized that the state, pursuant to its inherent police power, may enact regulations to promote the public health, safety, and welfare. *Michigan Canners & Freezers Ass'n, Inc v Agricultural Marketing & Bargaining Board,* 397 Mich 337, 343; 245 NW2d 1 (1976); *Grocers Dairy Co v Dep't of Agriculture Director,* 377 Mich 71, 75-76; 138 NW2d 767 (1966). Such regulations passed pursuant to the police power carry with them a strong presumption of constitutionality. *Shavers v Attorney General, supra,* p 613; *Michigan Canners, supra,* pp 343-344; *Grocers Dairy, supra,* p 76.

To overcome this presumption, the party challenging the act has the burden to show that no reasonable state of facts can be ascertained which would justify the enactment or, concomitantly, that the legislation bears no reasonable relationship to a legitimate governmental interest. *Shavers, supra,* pp 613-618; *Michigan Canners, supra,* pp 343-344.

In *Shavers, supra,* pp 612-613, this Court articulated the appropriate standard to be used when

ring in part) (certified question); *Shavers v Attorney General,* 402 Mich 554, 588-589; 267 NW2d 72 (1978) (declaratory judgment).

faced with a due process challenge to Michigan's no-fault act:

> The test to determine whether legislation enacted pursuant to the police power comports with due process is whether the legislation bears a reasonable relation to a permissible legislative objective. See *Michigan Canners v Agricultural Board*, 397 Mich 337, 343-344; 245 NW2d 1 (1976).

A. *§§ 104(3), 211, 414a, 415, and 607(1)*

As mentioned, BCBSM attacks these sections of 1980 PA 350 which restrict BCBSM's power to enter into ASO contracts on three separate constitutional grounds: impairment of private contract, violations of due process, and violations of equal protection. Because we find that these sections violate BCBSM's right to equal protection of law, see Part VII(A), we need not address BCBSM's due process argument.

B. *§ 206(4)*

BCBSM attacks § 206(4), which prohibits the packaging of health care services with lines of insurance, as violating due process of law.

We disagree.

In resolving this issue, we must determine whether § 206(4) bears a reasonable relation to a permissible legislative objective.

The life insurance market in Michigan has historically been very competitive, with the largest company today holding only about 9.56 percent of the market. One of the proffered objectives of § 206(4) is to protect the competitive nature of that

market.[51] It is feared that BCBSM's enormous resources and power would be used to destroy the competitive nature of the life insurance market. Eventually BCBSM would monopolize that market much as it dominates the health care market.

The other proffered objective of § 206(4) is to prevent BCBSM from monopolizing the health care market.[52] With its already dominant position, BCBSM could make its services even more attractive through packaging and thereby increase its share of that market.

We find these objectives or interests to be both legitimate and permissible. Free and fair competition is of unquestionable importance. See *Arlan's Department Stores, Inc v Attorney General,* 374 Mich 70, 75; 130 NW2d 892 (1964).

We also find that § 206(4) is both rationally and reasonably related to the demonstrated interests. If BCBSM were permitted to enter the life insurance market, there is evidence indicating that BCBSM could potentially capture a position in that market equal to the share it controls in the health care market.[53] This would obviously force out many other insurers or at least substantially reduce their share of the market and thereby reduce competition. Under BCBSM's present arrangement with ABL, BCBSM has already enabled ABL to capture a significant share of the life insurance market. ABL ranks 24th out of 323 companies selling such insurance in Michigan. In Oregon, Indiana, Wisconsin, and Utah, where BCBSM has packaging arrangements with ABL, in only a few short years

[51] See Circuit Court's Findings of Relevant Facts, Nos. 306-309, 322-323, 348-353.

[52] See Circuit Court's Findings of Relevant Facts, Nos. 309-310, 344-347.

[53] See Circuit Court's Findings of Relevant Facts, Nos. 306-309, 322-323, 348-353.

ABL has captured sizeable portions of the group life insurance market.[54]

With respect to the health care market, it should be noted that life insurance companies are only able to compete with BCBSM by packaging health care coverage with other lines of coverage.[55] If BCBSM were also permitted to package, this advantage held by the insurance companies would be effectively eliminated, and they would be unable to compete with BCBSM.

In accordance with the foregoing discussion, we reject BCBSM's attack on § 206(4) as being violative of the Due Process Clause.

C. *§ 401(7)*

BCBSM contends that by compelling it to now participate with state-owned psychiatric hospitals, § 401(7) of the act violates due process in that it forces BCBSM's subscribers to subsidize such institutions.

We disagree.

In the past, BCBSM's refusal to participate with state-owned psychiatric hospitals was based on the ground that those hospitals were taxpayer supported, unlicensed institutions, not subject to need planning restraints and without adequate cost accounting methods, a peer review system, or a community governing board. BCBSM further justified its policy of nonparticipation on the basis that more than adequate acute care beds were available at private psychiatric facilities to serve the needs of its subscribers and that participation would result in adding substantial costs to its operating expenses.[56]

---

[54] See Circuit Court's Findings of Relevant Facts, Nos. 352-353.

[55] See Circuit Court's Findings of Relevant Facts, No. 310.

[56] See Circuit Court's Findings of Relevant Facts, Nos. 368-370, 378.

By enacting § 401(7), the Legislature sought to correct the past discriminatory policies of BCBSM with respect to state-run mental hospitals. Simply stated, § 401(7) requires a health care corporation to accept, as a participating facility, any facility operated by the state or a political subdivision of the state which otherwise meets certain specified criteria for participation. The criteria specified in the act approximate the very reasons stated above for BCBSM's denial of participation status to state-owned mental hospitals.[57]

We find that the legislative response is reasonably related to the purpose of rectifying the discriminatory practice of BCBSM, which we note was specifically prohibited by the section of the Insurance Code regulating commercial health insurers.[58] Furthermore, this provision does nothing more than assure BCBSM's subscribers the unrestricted choice of treatment in any hospital which otherwise would qualify for participation, a duty which BCBSM owed its subscribers under the former enabling acts.[59] We therefore sustain this provision on due process grounds.

---

[57] Section 401(7) provides in relevant part:

"To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

"(a) Be accredited by the joint commission on accreditation of hospitals.

"(b) Meet the certification standards of the medicare program and the medicaid program.

"(c) Meet all statutory requirements for certificate of need.

"(d) Follow generally accepted accounting principles and practices.

"(e) Have a community advisory board.

"(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

"(g) Designate that portion of the facility which is to be used for acute care."

[58] Insurance Code, MCL 500.2237; MSA 24.12237 added by 1961 PA 133.

[59] MCL 550.503; MSA 24.623; see also *Blue Cross & Blue Shield of Michigan, supra,* pp 454-455 (LEVIN, J., *dissenting*).

D. *§ 217*

BCBSM contends that § 217, which states that upon dissolution and after the payment of debts the remaining assets shall escheat to the state, constitutes a taking without due process of law. Without knowing if or when BCBSM's assets will escheat to the state, the matter is too hypothetical or speculative to create an actual controversy. We do not consider this issue. See *Shavers v Attorney General, supra,* p 589; *Merkel v Long, supra,* p 13; *Evans Products Co v State Board of Escheats,* 307 Mich 506, 528-529; 12 NW2d 448 (1943).

E. *§ 502(1)(b)*

BCBSM finally argues that § 502(1)(b) which restricts "per case participation" by providers annually violates due process of law. There is no concrete proof on the record that this provision will definitely result in the reduction of per case participation claims by twelve and one-half to twenty-five percent, as alleged by BCBSM. The anticipated reaction of physicians to this provision and its effect on BCBSM and its subscribers is too speculative to determine now. Again, because BCBSM has failed to establish an actual controversy as to this issue, we do not address this constitutional challenge. See *Shavers v Attorney General, supra,* p 589; *Merkel v Long, supra,* p 13.

In sum, except for §§ 104(3), 211, 414a, 415, and 607(1) relating to ASOs, which we find violative of equal protection, and §§ 217 and 502(1)(b), which do not constitute an actual controversy, we do not find that any of these sections constitutes a due process violation.

VII. QUESTION 6

"VI. DO SECTIONS 104(3), 206(4), 211, 414a, 515

AND/OR 607(1) OF PA 350 DEPRIVE BCBSM OF THE EQUAL PROTECTION OF THE LAWS BY REGULATING BCBSM IN AN ARBITRARY AND DISCRIMINATORY MANNER WHICH BEARS NO RATIONAL RELATIONSHIP TO THE OBJECTS OF PA 350?"

BCBSM argues that certain statutory classifications of 1980 PA 350 unreasonably and arbitrarily discriminate against BCBSM vis-à-vis its competitors in deprivation of equal protection.

In *Shavers, supra,* pp 612-613, we observed that the test to determine whether legislation enacted pursuant to the police power comports with equal protection is essentially the same as that for due process. Consequently,

> "Under traditional equal protection analysis, a legislative classification must be sustained, if the classification itself is rationally related to a legitimate governmental interest." [Quoting from *United States Dep't of Agriculture v Moreno,* 413 US 528, 533; 93 S Ct 2821; 37 L Ed 2d 782 (1973).]

A. *§§ 104(3), 211, 414a, 415 and 607(1)—Administrative Services Only Contracts*

BCBSM attacks §§ 104(3), 211, 414a, 415, and 607(1), which restrict BCBSM's power to enter into ASOs,[60] on the ground that these sections violate BCBSM's right to equal protection. US Const, Am XIV; Const 1963, art 1, § 2.

The features of the act relevant here to BCBSM's equal protection challenges are as follows:

1. "Certificate" is defined to include ASO contracts, § 104(3).

---

[60] Administrative Services Only (ASO) contracts "refer to an arrangement whereby a health care coverage customer elects to be self-insured and pays the actual cost of claims, plus an administrative fee, instead of a flat insurance premium." See Circuit Court's Findings of Relevant Facts, No. 261.

2. Health care corporations may not enter into or continue in ASO arrangements with groups of less than five hundred subscribers, unless the arrangement was in existence in September of 1980, § 211.

3. Health care corporations are required to provide substance abuse and prosthetic device coverage to "certificate" holders. Substance abuse coverage must be provided upon issuance or renewal of a certificate and prosthetic device coverage must be provided on all certificates within twelve months after the effective date of the act, §§ 414a, 415.

4. Health care corporations must submit a copy of any new or revised "certificate" along with proposed rates to the Commissioner of Insurance for approval, § 607(1).

BCBSM attacks the above provisions only as they apply to ASO contracts. It contends that these sections result in a "grossly discriminatory treatment of BCBSM vis-à-vis its competitors." Furthermore, BCBSM argues that there is no logical or reasonable basis for this disparate treatment, because "ASO business practices are virtually *identical*, whether conducted by BCBSM or commercial insurers."

We agree.

In resolving BCBSM's equal protection challenge, we must determine whether the classification itself is rationally related to a legitimate governmental interest.

Sections 104(3), 414a and 415 combine to mandate that BCBSM include substance abuse and prosthetic device coverage in its ASO contracts. There is no such requirement with respect to commercial insurers' marketing of ASO contracts. See MCL 500.5208, 500.5208a; MSA 24.15208, 24.15208(1). See also MCL 500.3425, 500.3609; MSA 24.13425,

24.13609. Sections 104(3) and 607(1) operate to require prior approval of the commissioner before BCBSM enters into an ASO arrangement. Again, there is no such requirement for commercial insurers. See MCL 500.5208, 500.5208a; MSA 24.15208, 24.15208(1). Finally, § 211 prohibits BCBSM from offering ASO contracts to groups of under five hundred employees. BCBSM's competitors are permitted to offer ASO contracts to groups of five hundred "employees and members." See MCL 500.5208(2)(c); MSA 24.15208(2)(c). There are generally two and one-half members per employee. Hence, BCBSM's competitors are allowed to enter into ASO contracts with groups of considerably less than five hundred "employees."

The Attorney General attempts to justify the discriminatory treatment of §§ 414a and 415 by pointing to need for substance abuse and prosthetic device coverage. We do not doubt the need for such coverage. However, we fail to understand why the need for such coverage is any greater with respect to BCBSM than it is with respect to BCBSM's competitors. See *Hartford Steam Boiler Inspection & Ins Co v Harrison,* 301 US 459, 461-463; 57 S Ct 838; 81 L Ed 1223 (1937). The Attorney General offers us no explanation, and we are unable to conceive of one.

The Attorney General, however, goes on to argue that all of the sections are constitutionally sound because the Legislature may approach a problem in a piecemeal fashion. In support of this contention, the Attorney General cites *Metropolitan Funeral System Ass'n v Ins Comm'r,* 331 Mich 185, 194; 49 NW2d 131 (1951), where this Court stated:

> "A State may properly direct its legislation against what it deems an existing evil without

> covering the whole field of possible abuses. . . . The statute must be presumed to be aimed at an evil where experience shows it to be most felt, and to be deemed by the legislature coextensive with the practical need; and is not to be overthrown merely because other instances may be suggested to which also it might have been applied." [Quoting *Kelly v Recorder's Court Judge*, 239 Mich 204, 215; 214 NW 316 (1927), quoting *Whitney v California*, 274 US 357, 369-370; 47 S Ct 641; 7 L Ed 1095 (1927).]

We still concur in the foregoing reasoning. Nonetheless, all evidence indicates that the evils associated with ASOs are the same regardless of who is marketing them. For example, it seems to be conceded that the risk factor varies with the size of the group. It seems that the smaller the group, the greater the possibility that there will be a larger variation in the claims that must be borne by that group. With groups of under five hundred, this fluctuation is most likely. Hence five hundred or more seems to be the optimum size. But if five hundred or more is the optimum size, it is so regardless of who is marketing the ASOs. This risk factor has no correlation with the discriminatory treatment of BCBSM here. The classification still must have an adequate or reasonable basis. *Van Slooten v Larsen, supra*, 410 Mich 55-56; *Metropolitan Funeral System Ass'n v Ins Comm'r, supra*, p 194, quoting *Kelly v Recorder's Court Judge, supra*, p 215, quoting *Whitney v California, supra*, pp 369-370. The Attorney General has failed to present such a basis, and we are unable to think of one.

Moreover, we note that § 211's requirement that BCBSM not offer ASO contracts to groups of under five hundred employees is in fact contrary to the noted facts. Since there are generally two and one-

half members per employee, BCBSM is only allowed to contract with groups of considerably larger than five hundred. If five hundred or more is the optimum number, then we see little reason why BCBSM should be permitted to enter ASO arrangements only with groups much larger than five hundred.

Next, the Attorney General argues that BCBSM never had the right under the old acts, 1939 PA 108 and 109, to enter into ASO arrangements. See 1939 PA 108, § 2(1); 1939 PA 109, § 1. Even assuming that this is true, however, this has no bearing upon BCBSM's equal protection argument challenging the relevant sections of 1980 PA 350, which allow BCBSM to enter into ASO contracts, but under restraints not imposed on BCBSM's competitors. The state still must treat BCBSM and its competitors equally, unless the classification is rationally related to a legitimate governmental interest. As stated, this it has failed to do.

Finally, the Attorney General attempts to justify § 607(1), which gives the commissioner approval power over BCBSM's ASO contracts, by stating that the commissioner has always had such power. We are unable to locate any provision so empowering the commissioner. In any event, just because the commissioner was so empowered before does not make such power as authorized by § 607(1) any less violative of the Equal Protection Clause.

In sum, we hold that insofar as §§ 104(3), 211, 414a, 415, and 607(1) result in the arbitrary and discriminatory treatment of BCBSM's ASO arrangements, they are unconstitutional.

B. *§ 206(4)*

BCBSM asserts that § 206(4) violates its right to equal protection by forbidding BCBSM to engage in packaging while BCBSM's commercial competitors

are not similarly restricted. Although § 206(4) denies BCBSM the right to package, it is not an unreasonable classification. BCBSM is a health care corporation and not an insurance company. The state may create separate classifications for regulating various kinds of corporations where the regulation directly relates to the inherent differences between the corporations. See *Metropolitan Funeral System Ass'n v Ins Comm'r, supra,* pp 193-194 (wherein this Court held that the inherent differences between insurance companies and funeral benefit associations justified the statutory prohibitions on the former and not on the latter).

The restrictions on packaging, unlike those on ASOs, arise out of the inherent differences between insurance companies and health care corporations. The function of health care corporations is to market health care and not insurance. Packaging here involves the marketing of insurance, whereas ASOs involve the marketing of health care. Therefore, the differences between insurance companies and health care corporations justify the restrictions on packaging, but not on ASOs. We thus find that § 206(4) is neither arbitrary nor unreasonable and sustain it on equal protection grounds.

VIII. QUESTION 7

"VII. DO SECTIONS 402(7), 404(5), 605 AND/OR 701(5) OF PA 350 DEPRIVE BCBSM OF LIBERTY AND PROPERTY WITHOUT DUE PROCESS OF LAW BY PRIVIDING FOR ADMINISTRATIVE PROCEDURES LACKING IN FUNDAMENTAL DUE PROCESS GUARANTEES?"

BCBSM next challenges several sections of 1980 PA 350 on procedural due process grounds. BCBSM alleges three areas of deficiency—failure to provide an impartial decisionmaker, improper burden of proof, and failure to provide notice and hearing—in several sections.

A. *Failure to Provide an Impartial Decisionmaker —§§ 402(7), 404(5) and 605*

BCBSM asserts that two statutory provisions improperly grant the Insurance Commissioner the authority to review, in a judicial capacity, decisions previously made in a prosecutorial capacity, and that a third section allows the Insurance Commissioner to review judicial decisions by the commissioner. BCBSM complains that these statutorily assigned dual roles of the Insurance Commissioner violate the corporation's constitutional guarantee of a fair hearing before an impartial tribunal.[61] BCBSM challenges the dual functions as inherently defective situations only; no allegation of actual bias is directed at the Insurance Commissioner. We find that these issues present no actual controversy at this time.

BCBSM alleges that §§ 402(7) and 605 improperly combine prosecutorial and adjudicative functions.

Section 402(6) authorizes the Insurance Commissioner to bring a complaint against the health care corporation upon probable cause that the corporation has violated the act. If an informal conference cannot resolve the dispute, a hearing is held pursuant to MCL 500.2030; MSA 24.12030 and in accordance with the Administrative Procedures Act. MCL 500.2030; MSA 24.12030, part of the uniform trade practices act, directs that "[t]he commissioner or his designate shall preside over the hearing, except that an independent hearing officer shall be designated by the commissioner if requested by the person who is the subject of the proceedings." If after the hearing the commissioner determines that the health care corporation has violated the act, the commissioner may issue a cease and desist order. § 402(7).

[61] US Const, Am XIV; Const 1963, art 1, § 17.

Section 605(2) permits the Insurance Commissioner to order a summary suspension or limitation of the corporation's certificate of authority. The section continues: "The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated."

We find nothing in these sections presenting an actual controversy. It is not at all apparent that the same individuals will ever assume both prosecutorial and adjudicative roles.

The act provides that the Insurance Commissioner may delegate authority. Section 104(5) defines "commissioner" to include "an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601." Thus, it is quite possible that the dual role situation hypothesized by BCBSM will never materialize. This Court declines to address such speculative questions.

Additionally, BCBSM attacks § 404(5), complaining that this section improperly allows the Insurance Commissioner to review prior adjudication by the commissioner (as opposed to prosecutorial decisions), again in flagrant violation of the right to an impartial decisionmaker.

Section 404(4) directs the Insurance Commissioner to establish by rule a procedure for informal dispute resolution.

> The commissioner *shall* by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, *while protecting the interests of both the person and the health care corporation.* [Emphasis added.]

This statute thus delegates rulemaking author-

ity to the Insurance Commissioner. Such delegation withstands constitutional scrutiny if sufficient standards are incorporated to direct the agency's action. *Dep't of Natural Resources v Seaman*, 396 Mich 299, 309; 240 NW2d 206 (1976). Here, the Insurance Commissioner is directed to "[protect] the interests of both the person and the health care corporation." Subsumed under the direction to protect the parties' "interests" must be the duty to protect the parties' fundamental due process guarantees which include an impartial decision-maker.

At the present time, because of the injunction, the Insurance Commissioner has not exercised her authority under this statute; she has promulgated no rules to establish an informal dispute resolution procedure. We have no reason to believe that when this power is exercised individual constitutional rights will not be respected. Therefore at the present time there is no actual controversy. See *Sullivan v Board of Dentistry*, 268 Mich 427, 429; 256 NW 471 (1934).[82]

---

[82] In *Sullivan v Board of Dentistry, supra*, the Court dismissed plaintiff's action seeking a declaration that the statute delegating to the Board of Dentistry the power to promulgate rules governing the practice of dentistry was unconstitutional. The Court held that the case presented no actual controversy, explaining:

"No rules or regulations have thus far been promulgated by the board, nor is it shown that any have been submitted to the attorney general to establish their legality. It is not to be presumed that the board will adopt any rules and regulations for the practice of dentistry that do not meet the test of constitutionality. It is not our duty to pass on moot questions or abstract propositions. As no unconstitutional rule has been pointed out, the presumption of the constitutionality of the act remains."

Accord, *Evans Products Co v State Board of Escheats*, 307 Mich 506, 529; 12 NW2d 448 (1943). Likewise, BCBSM's challenge to § 404(4) poses the same type of hypothetical premature issue.

In contrast, BCBSM's challenge that the actuary panel has been unconstitutionally delegated legislative power (see Part IV[B]) does not present a hypothetical issue. If the act had merely permitted the Insurance Commissioner to develop regulations to guide an inquiry, we would have presumed that the commissioner would act constitutionally and judged the issue premature.

B. *Burden of Proof—§ 402(7)*

BCBSM next complains that §§ 402(6) and (7) establish too low a burden of proof upon which the Insurance Commissioner may issue an order regarding statutory violations. Section 402(6) provides that the Insurance Commissioner may bring a complaint against the corporation when the Insurance Commissioner has "probable cause to believe" that the health care corporation has violated the provisions of § 402. Section 402(7) provides that after notice of the complaint is given, a hearing will be held, then continues:

> If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, *or has probable cause to believe* that the corporation is violating, or has violated subsection (2), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. [Emphasis added.]

BCBSM argues that the issuance of an order solely on the basis of a finding of probable cause is improper. We agree.[83]

However, the delegation challenge is more concrete. The Insurance Commissioner is given an open, unrestricted grant of authority to approve or disapprove the proposed risk factors. The Legislature must provide *some* standards or policy articulation, even if quite minimal, in order to constitutionally delegate power. No agency action can rectify this constitutional defect. Thus, the issue is not premature; an actual controversy is presented.

[83] BCBSM frames its argument in terms of a denial of due process. However, plaintiff fails to demonstrate the constitutional underpinnings of this claim. Therefore, rather than address this claim as one of constitutional dimension, we will consider it as a purely evidentiary question.

It is generally well established that issues of fact in civil cases are to be determined in accordance with the preponderance of the evidence with the burden of persuasion placed upon the party asserting the claim. McCormick, Evidence (2d ed), § 339, p 793; 30 Am Jur 2d, Evidence, § 1163, p 337; *Stone v Earp,* 331 Mich 606, 611; 50 NW2d 172 (1951); *Martucci v Detroit Police Comm'r,* 322 Mich 270, 274; 33 NW2d 789 (1948). In *Aquilina v General Motors Corp,* 403 Mich 206, 210; 267 NW2d 923 (1978), this Court stated that the same burden of persuasion applies to proceedings before an administrative agency. Accord, Cooper, *State Administrative Law,* p 355.

Proof by a preponderance of the evidence requires that the factfinder believe that the evidence supporting the existence of the contested fact outweighs the evidence supporting its nonexistence. *Martucci v Detroit Police Comm'r, supra,* p 274.

Under § 402, the Insurance Bureau is authorized to bring a complaint charging BCBSM with a violation of § 402. The Insurance Commissioner must therefore prove its allegations at the subsequent hearing by a preponderance of the evidence. The statute, however, requires only a probable cause standard.

A probable cause determination does not involve the comparing and weighing of facts as required by the preponderance of evidence standard. A probable cause finding requires only facts which would induce a fair-minded person of average intelligence and judgment to believe that the statute was violated. *People v Oliver,* 417 Mich 366, 374; 338 NW2d 167 (1983). Thus we agree with BCBSM that the statute directs the application of

an inappropriate standard in the § 402 administrative proceeding.[64]

C. *Failure to Provide Notice or Hearing—§ 701(5)*

Finally, BCBSM asserts that § 701(5) of the act completely ignores the due process guarantee of notice and an opportunity to be heard. Section 701 allows an existing health care corporation 120 days to amend its articles of incorporation and bylaws and to restructure its board of directors and thereby achieve compliance with the act. The corporation may continue to operate under its old structure during this 120-day grace period. However, if at the completion of the 120 days the corporation has failed to comply with the act, § 701(5) provides:

> If a health care corporation fails to comply with this section the commissioner may issue an order suspending the right and privilege of the corporation to sell or issue new certificates until this section has been fully complied with.

BCBSM argues that because this section fails to provide for notice and hearing, due process is denied.

However, a statute must be read in its entirety, *Metropolitan Council No 23, AFSCME v Oakland County Prosecutor*, 409 Mich 299, 317; 294 NW2d 578 (1980), with a presumption of constitutionality. *Johnson v Harnischfeger Corp*, 414 Mich 102, 112; 323 NW2d 912 (1982); *Workman v Detroit Automobile Inter-Ins Exchange*, 404 Mich 477, 507-508; 274 NW2d 373 (1979).

---

[64] Although the Court is not presented with an actual § 402(6) determination based upon probable cause at this time, we nonetheless find this issue to be an actual controversy. The statute sets forth a burden of proof which is blatantly incorrect; no further development of facts is necessary to expose the problem; no action of the Insurance Commissioner could erase this incorrect burden of proof from the statute.

Thus, while § 701(5) itself contains no reference to required procedural protections regarding the commissioner's right to suspend certificates of authority, § 605(1) supplies the necessary procedures with reference to the specific instance involved in § 701. Section 605(1) reads:

> *Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative procedures act,* the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:
>
> • • •
>
> (c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner. [Emphasis added.]

Thus, when § 701(5) is read in conjunction with § 605(1), due process is fully satisfied.[65]

---

[65] BCBSM also briefly alludes to possible notice and hearing deficiencies with regard to § 605(2), which provides that upon a finding "that the public health, safety, or welfare requires emergency action" the Insurance Commissioner may order a summary suspension or limitation of a certificate of authority. The section also states: "The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated."

BCBSM's full discussion of its challenge to § 605(2) reads:

"If the commissioner finds that 'emergency action' is required, he/she can summarily suspend BCBSM's certificate of authority, *without notice or hearing.*" (Emphasis in original.)

The short answer to this claim is that due process does not require notice and hearing prior to deprivation of a property right in every case. *Miller v Dep't of Treasury,* 385 Mich 296, 334; 188 NW2d 795 (1971); *Rockwell v Crestwood School Dist Board of Education,* 393 Mich 616, 633; 227 NW2d 736 (1975); 1 Davis, Administrative Law, § 7.08, pp 438-444. In *Miller,* this Court explained:

"' "Discretion of any official may be abused. Yet it is not a requirement of due process that there be judicial inquiry *before discretion can be exercised. It is sufficient, where only property rights are concerned, that there is at some stage an opportunity for a hearing and judicial determination. . . .*" (Emphasis added.)' " Quoting *Ewing v Mytinger & Casselberry, Inc,* 339 US 594, 599; 70 S Ct 870; 94 L Ed 1088 (1950).

IX. QUESTION 8

"VIII. DO SECTIONS 106(5), 205(4), 205(5), 310(1), 401(1), 503, 504(1), 509(1), 509(4)(b), 510(1), 511(1) AND/OR 513(1) OF PA 350 DEPRIVE BCBSM OF LIBERTY AND PROPERTY WITHOUT DUE PROCESS OF LAW BY IMPOSING UNCONSTITUTIONALLY VAGUE AND ILLUSORY DUTIES ON BCBSM AND THE COMMISSIONER OF INSURANCE?"

BCBSM argues that various sections of the act include vague and illusory terms, and thus unconstitutionally deny BCBSM sufficient warning of its duties under the act. For instance, BCBSM challenges § 205(4) which directs:

> A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business.

BCBSM correctly points out that "lines of business" is nowhere defined in the statute, and concludes: "The assignment of risk factors and ultimate determination of BCBSM's contingency reserves would be greatly altered depending on the meaning attributed to the term 'lines of business.'" BCBSM also specifically challenges the terms: "fiduciary [duty] toward the health care corporation and the subscribers," § 310(1); "health care benefits," § 401(1); "address the issue of uniform reporting," § 503 and "reasonable access, cost and quality" in relation to health care services, §§ 106(5), 504(1), 509, 510, 511, 513.

It is a general principle of constitutional law that statutory language must be sufficiently clear and definite to provide fair warning of proscribed

Under § 605(2) summary action is prompted by an emergency situation; the action is reviewed in an adversarial hearing within five days. While future application of this statute might expose latent deficiencies, in the present posture we find no due process violation.

conduct. *People v Dempster,* 396 Mich 700, 715; 242 NW2d 381 (1976). However, as noted by this Court in *People v Howell,* 396 Mich 16, 21; 238 NW2d 148 (1976), statutes which do not involve First Amendment freedoms must be examined in light of the facts of the case at hand. The *Howell* Court cited *United States v National Dairy Products Corp,* 372 US 29, 32; 83 S Ct 594; 9 L Ed 2d 561 (1963), which further elucidates the problem associated with insubstantial vagueness challenges:

> "The delicate power of pronouncing an Act of Congress unconstitutional is not to be exercised with reference to hypothetical cases . . . . [A] limiting construction could be given to the statute by the court responsible for its construction if an application of doubtful constitutionality were . . . presented. We might add that application of this rule frees the Court not only from unnecessary pronouncement on constitutional issues, but also from premature interpretations of statutes in areas where their constitutional application might be cloudy." [Quoting *United States v Raines,* 362 US 17, 22; 80 S Ct 519; 4 L Ed 2d 24 (1960).]

The present statute has not yet brought BCBSM and the Insurance Commissioner into an actual adversarial relationship over the statutory terms. BCBSM is not yet defending its definition against a conflicting position asserted by the Insurance Commissioner. BCBSM hypothesizes areas of possible future confrontation, but on the present record we do not have an actual controversy to justify a constitutional analysis.

X. QUESTION 9

"IX. DOES SECTION 301(7) OF PA 350 DEPRIVE

BCBSM, ITS DIRECTORS, OFFICERS AND MEMBERS OF GUARANTEED RIGHTS OF FREE SPEECH?"

BCBSM attacks § 301(7) of 1980 PA 350, MCL 550.1301(7); MSA 24.660(301)(7), under US Const, Am I, and Const 1963, art 1, § 5, which guarantee the right of free speech. BCBSM argues that "[t]his section deprives BCBSM, its directors, officers and corporate members of guaranteed rights of free speech and clearly violates" art 1, § 5 of the Michigan Constitution and the First Amendment of the United States Constitution.

The act vests authority to amend the bylaws in the board of directors (§ 301[1]). It then sets forth the membership of the board, limits the number of provider directors to not more than twenty-five percent (§ 301[3]) and provides that the remaining members shall include representatives of subscriber groups in proportions which fairly represent the total subscriber population of the health care population (§ 301[5]).

Section 301(6) then provides that the method of selection of the directors shall be specified in the bylaws.

Section 301(7) provides that the method of selection of subscribers shall maximize subscriber participation, and that:

> The method of selection [established by the bylaws] shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to participate in the selection

process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.[66]

There are two plausible constructions of subsection (7). The section could be read in conjunction with subsection (5) as precluding the bylaws from permitting or requiring the named groups from promoting or inhibiting the selection of *subscriber* members, or it could be read more broadly to limit these entities with respect to the selection of all members of the board (other than the public members, § 301[6], and the single officer/employee director authorized in § 301[4]).

Since neither party has briefed this issue, we do not need to resolve which interpretation is correct. Neither view is a direct limitation on any individual, management or corporate right of expression. Properly viewed, subsection (7) is a limitation on the method of selection to be ultimately adopted by the board of directors in the bylaws; that is, a directive that the selection process may not be impeded by a provision *in the bylaws* which either requires or permits the named entities to nominate, endorse, approve or confirm "a candidate or director." Since the bylaws relating to the selection process have not yet been amended, nor is there a suggestion as to how the board wishes to revise the bylaws, there is no actual case or controversy at this time.

If subsection (7) is subsequently interpreted by the Insurance Commissioner to impose a limitation on corporate expenditures or other expressions of influence which conflicts with the bylaws adopted by the board of directors, then a free exercise challenge would be presented. That, of course, is a

[66] Subsection (4), MCL 550.1301(4); MSA 24.660(301)(4), authorizes not more than one officer or employee of the health care corporation to serve as a voting or nonvoting director.

wholly speculative matter, to be resolved when a case or controversy is presented. In short, we hold that subsection (7) is not a limitation of expression, but rather a limitation on the method of selection which the board through its bylaws may adopt. We therefore conclude that no cognizable constitutional challenge has here been advanced.

CONCLUSION

For the reasons more fully discussed in our analyses of the questions certified to this Court, we uphold the constitutionality of the challenged sections of 1980 PA 350 except as follows:

First, we agree that the act is unconstitutional in the following three particulars:

(1) the Act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards, § 205(6) (Question 3);

(2) the statutory restrictions on ASO contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-à-vis commercial insurers, §§ 104(3), 211, 414a, 415, and 607(1) (Questions 4, 5 and 6);

(3) the commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof, § 402(7) (Question 7).

Our ruling on these three areas of 1980 PA 350 does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. *People v McMurchy*, 249 Mich 147, 157-159; 228 NW 723 (1930).

Second, we do not consider whether the act is unconstitutional in the following five particulars because there was no actual case or controversy established:

(1) whether §§ 509(4)(b), 516(2)(b), and 510 impair the private existing contracts between BCBSM and its participating providers (Question 4);

(2) whether § 217 relating to BCBSM's assets escheating to the state upon dissolution, and § 502(1)(b), relating to per case participation, deprive BCBSM of due process of law (Question 5);

(3) whether §§ 402(7), 404(5), and 605 fail to provide for an impartial decisionmaker in violation of due process of law (Question 7);

(4) whether §§ 106(5), 205(4), 205(5), 310(1), 401(1), 503, 504(1), 509(1), 509(4)(b), 510(1), 511(1), or 513(1) impose unconstitutionally vague and illusory duties on BCBSM and the commissioner (Question 8);

(5) whether § 301(7) deprives BCBSM, its directors, officers and members of free speech (Question 9).

Accordingly, we remand this matter to the trial court with instructions to dissolve the injunction and to take such further action as is consistent with this opinion.

No costs, a public question being involved.

BRICKLEY, CAVANAGH, and BOYLE, JJ., concurred with WILLIAMS, C.J.

RYAN, J., concurred in the result only.

LEVIN, J. My principal disagreement with the majority concerns the validity of the provisions of 1980 PA 350 requiring Blue Cross and Blue Shield of Michigan to reincorporate under that act and to thereby transfer control of BCBSM from the members of that corporation, who theretofore elected

the directors of BCBSM, to BCBSM subscribers and others who are empowered by that act to elect or appoint seventy-five percent of the directors. I would hold that those provisions effect a taking of "private property"[1] within the meaning of the Constitutions of the United States[2] and of this state[3] and that the failure of the act to provide for the making or securing of just compensation therefor renders those provisions of the act invalid under the Michigan Constitution.[4]

A

The governance issue is primary. If the provisions of Act 350 transforming the governance of BCBSM are valid, it is of less importance whether the other provisions challenged by BCBSM are valid. If the governance of BCBSM can be changed by legislative fiat, then those who would—now or in the future—challenge the validity of other provisions of the act or further amendatory legislation or regulations or orders promulgated by the Commissioner of Insurance or the opinions of the Attorney General regarding the meaning of the act may, by further amendatory legislative decree, find that their tenure is at an end. The rationale

[1] As set forth in n 24 and the accompanying text, there is no need in the instant case to reach the question whether the taking is for a public use.

[2] Fifth Amendment of the Constitution of the United States as applied to the states through the Fourteenth Amendment. See *Webb's Fabulous Pharmacies, Inc v Beckwith*, 449 US 155, 160; 101 S Ct 446; 66 L Ed 2d 358 (1980).

[3] Const 1963, art 10, § 2.

[4] The remedy question, see *San Diego Gas & Electric Co v City of San Diego*, 450 US 621; 101 S Ct 1287; 67 L Ed 2d 551 (1981), need not be addressed because BCBSM is not seeking compensation for an inverse condemnation. The state has not offered to pay compensation, and the Michigan Constitution, in contrast with the Fifth Amendment of the Constitution of the United States, requires that before private property is taken for a public use just compensation therefor must be "*first* made or secured in a manner prescribed by law."

of the opinion of the Court means, in effect, that all the members of the BCBSM board serve under the Sword of Damocles at the pleasure of the Legislature and Governor.

B

BCBSM asserts that implementation of Act 350 would constitute a government takeover of BCBSM, its business, and its property. I agree.

All agree that a purpose of Act 350 is to eliminate control of BCBSM, and hence of its business and properties, by the persons presently in control and to transfer control to others, persons appointed by the Governor and elected by providers and subscribers.

To be sure, there has been no change in legal title. BCBSM, the corporation, remains the owner of all the assets that it formerly owned. Bare legal title without control, however, might well be meaningless. The law does not necessarily treat the holder of bare legal title as the owner. The person who has the power to possess, use, control, and acquire the property may be treated as the owner.

In the instant case, although the state does not take title to or possession of the assets of BCBSM, it would exercise control by means of a legislative enactment which designates who shall exercise control; BCBSM has in effect become a controlled subsidiary of the State of Michigan.[5]

The state has, in effect, asserted the right to own a majority of the voting interest in BCBSM. The state has arrogated to itself the powers (i) to designate or confer on persons designated by it the

[5] A parent corporation does not directly own the assets of a subsidiary corporation; it nevertheless is in control through the ownership of a majority of the capital stock.

power to elect a majority of the directors, (ii) to change the purposes of the corporation, and (iii) upon a dissolution (which its designees could bring about), to have the assets of BCBSM turned over to the state.

All who hold office and power pursuant to Act 350 do so at the sufferance of the Legislature and Governor. Control of BCBSM and of its business and properties is now subject to legislative directive. Having so arrogated to itself the power to control the use of the properties of BCBSM, the properties of BCBSM have ceased to be private property and have, by legislative fiat, become public property.

C

The majority rely on *Penn Central Transportation Co v City of New York*, 438 US 104; 98 S Ct 2646; 57 L Ed 2d 631 (1978). Suppose the New York Legislature had not passed the air-rights legislation considered in *Penn Central*, but rather a law stating that the use of the properties known as Grand Central Station shall henceforth be controlled by a committee appointed by the Governor of New York and elected by persons (voting by classes, if you will) who use the station, commuters, long-distance travelers, persons who work and shop there. There would be no change in title, the asset known as Grand Central Station would remain in the name of Penn Central. It would retain the right to receive whatever income was derived. But the use and operation of Grand Central Station would be subject to the directives of the committee appointed pursuant to the legislation. Surely, it could not then be said that Grand Central Station remained private property. The State of New York would surely have been held to have taken Grand Central Station.

So too here. The use and operation of the properties of BCBSM will henceforth be subject to the directives of a committee, called a board of directors, appointed pursuant to Act 350. Although title to the assets and properties of BCBSM remain in its corporate name, that committee, which serves at the sufferance of the Legislature and Governor, will henceforth run BCBSM. It can no more be said that the business and properties of BCBSM remain private property than it could be said that Grand Central Station would have remained private property. The assets and properties of BCBSM will have been taken over by the State of Michigan.

D

The challenged provisions of Act 350 cannot be justified on the basis that the state has taken over control of the BCBSM assets, properties, and business with a view to better serve the purposes for which BCBSM was organized or that BCBSM is organized as a not-for-profit corporation. Conceding that the assets, properties and business of BCBSM might be subject to fiduciary obligations of some sort, those assets, properties and business are nevertheless private property. Absent a judicial finding that directors or officers of BCBSM have misused the assets and properties of BCBSM, the state cannot lawfully put BCBSM into receivership.

In focusing on the purpose for which BCBSM was organized and that is a not-for-profit corporation, the Court confuses the purpose for which control or ownership must be exercised with the questions whether control and the assets, properties, and business subject to control are private property and whether the state can purport to separate legal title and control without effectuating a taking of the assets, properties, and business subject

to that control. I would hold that it cannot. The assets, properties, and business of a corporation, profit or not-for-profit, are taken if the power to elect a majority of the directors is taken. The power to direct the use and disposition of assets and property and the business are at least a substantial strand, perhaps the core strand, of the property interests in those assets.

Whether the assets, properties, and business of BCBSM and control thereof belong to the members of the corporation or to the corporation or are superimposed with a fiduciary obligation requiring that they be used to further the corporate purpose or the public interest or even the interest of subscribers need not be decided. The central point is that those interests in property are private property, and neither the property interest in control nor the assets, property, or business subject to that control belongs to the state. When the state redistributes control, it has gone beyond mere regulation and has taken *both* control and the assets, properties, and business subject to control.

Nor is it material that the members would not have the right to use for themselves just compensation paid pursuant to the Takings Clause were it to be paid. Neither would the directors of the United Foundation nor the Kellogg nor Ford Foundations have the right to do so if property of those foundations were to be taken. Surely, the fact that no member or officer of a not-for-profit corporation would have the right personally to use just compensation paid for the taking of property or interest in property respecting the not-for-profit corporation does not justify a court holding that the failure to pay just compensation for the taking of the property of a not-for-profit corporation is harmless error.

In sum, the assets, properties and business of BCBSM, including control, are private property protected by the Takings Clause. BCBSM cannot be made a subsidiary of the State of Michigan without exercise of the power of eminent domain.[6]

I

BCBSM commenced this action seeking a declaratory judgment that Act 350 is unconstitutional. The circuit judge enjoined enforcement of the act and ordered the parties to comply with the original enabling acts under which BCBSM was incorporated, 1939 PA 108 and 109.[7] The controversy is now before us on certified questions of public moment[8] following an evidentiary hearing and the filing by the judge of findings of fact.

In parts III-XIII of this opinion, I consider challenges to provisions of the act including provisions imposing limitations concerning BCBSM provider contracts, marketing practices, and rates charged subscribers. In part III, I set forth my conclusions in summary form. I now turn to a consideration of the fundamental governance issue.

---

[6] It has been suggested at conference that BCBSM does not have standing to raise the issue of the members' loss of control, that they alone can raise this issue, and that the failure of any member to join in the complaint forecloses a decision predicated on member loss of control. It is now established that majority stockholders of a profit corporation hold the property interest in control for the benefit of the corporation and minority stockholders. Henn, Corporations (2d ed), § 188, pp 490 *ff*. On the same principle, the property interest in control of a not-for-profit corporation belongs to the corporation and possibly all the members, those in the minority as well as those in the majority. Further, under the circumstances that this litigation has been pending for a number of years and the Legislature and the people need a decision on the fundamental takeover issue and the Attorney General does not contest the standing of BCBSM to raise the takeover issue, the Court should decide it on the merits. Otherwise that fundamental issue would remain undecided awaiting still further litigation.

[7] MCL 550.301; MSA 24.591, MCL 550.501; MSA 24.621.

[8] GCR 1963, 797.1.

II

BCBSM, like most not-for-profit corporations,[9] is organized as a membership corporation.[10] The members generally control the enterprise through the power to elect directors and the powers, generally retained, to perpetuate control by electing new members, adopting and amending bylaws and amending the articles of incorporation.

Act 350 requires BCBSM to reincorporate under that act.[11] The act retains the form of a membership corporation, but eliminates the substance by (i) eliminating the powers of members (or of directors elected by members)[12] to elect directors and amend the articles and bylaws, and (ii) providing that seventy-five percent of the directors and members shall be elected or appointed by BCBSM subscribers and other persons who are not now members of BCBSM.

The act provides that the board of directors shall not exceed thirty-five persons. Four of the directors shall be appointed by the Governor. Not more than twenty-five percent may be providers (physicians and hospitals). One may be an officer of BCBSM. The remaining twenty-two directors shall be elected by subscribers. Six of the eight provider directors shall be "as broadly representative of provider classes as possible." The "method of selection of each category of subscribers . . . shall maximize subscriber participation to the extent reasonably practicable."[13]

---

[9] MCL 450.117 *et seq.*; MSA 21.118 *et seq.*

[10] MCL 550.302-550.303; MSA 24.592-24.593, MCL 550.501; MSA 24.621, MCL 550.504; MSA 24.624.

[11] MCL 550.1701; MSA 24.660(701).

[12] The validity of a self-perpetuity board of directors is not in issue and I express no opinion thereon.

[13] "Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act

A purpose of this legislation, as set forth in the opinion of the Court,[14] is to reduce or eliminate control of BCBSM by the providers who originally organized BCBSM[15] and who have largely influenced

shall be held and managed by a board of directors to consist of *not more than 35 members*. . . .

"(2) *Four* voting members of the board shall be representatives of the public appointed *by the Governor* by and with the advice and consent of the senate. . . .

"(3) The board of directors shall consist of *not more than 25% provider directors*. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional *nurse* who shall be representative of licensees under part 172 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the calendar year immediately preceding the effective date of this act in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as *broadly representative of provider classes* as possible.

"(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

"(5) The *remaining members of the board* of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

"(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. . . .

"(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall *maximize subscriber participation to the extent reasonably practicable.*" MCl 550.1301(1)(7); MSA 24.660(301)(1)(7). (Emphasis supplied.)

[14] *Ante*, pp 35, 47, 62.

[15] See Hollister & Drake, *The Nonprofit Health Care Corporation Reform Act of 1980*, 14 U Mich J L Ref 433, 435-436 (1981).

and may still dominate and control BCBSM;[16] and to transfer from the current members of BCBSM to subscribers and providers—elected in the manner provided in Act 350 and not in the manner provided by the articles of incorporation and bylaws of BCBSM—and the persons elected by them and to the four appointees of the Governor the power to control the business of BCBSM.[17]

Because BCBSM—like other not-for-profit corporations—must be operated solely for the not-for-profit purpose for which it was organized, the current members of BCBSM, their successors—the directors they elect—not subscribers or the people —have the established property right to determine how that purpose shall be achieved.

A

The opinion of the Court indicates that the change in the governance of BCBSM is a governmental regulation enacted in the exercise of the "police power"[18] to promote "health, safety, morals

[16] The circuit judge found that there was no competent evidence that "the current board of directors of BCBSM is, or is not, provider dominated."

[17] The act further provides for the establishment of a membership of BCBSM composed of subscribers, providers and appointees of the Governor selected in essentially the same manner and proportions as are directors:

"Sec. 305. (1) A health care corporation may establish a corporate body. The corporate body shall consist of individuals *selected in the same manner as individuals are selected to serve as nonpublic members on the board of directors.* The size of the corporate body shall be such that, for each nonpublic voting director on the board of directors of the corporation, there are 2 members of the corporate body. The 4 public members selected pursuant to section 301(2) shall be considered to be members of the corporate body as well as members of the board of directors. An additional 4 public members shall be appointed to the corporate body by the governor by and with the advice and consent of the senate. . . ." MCL 550.1305; MSA 24.660(305). (Emphasis supplied.)

[18] *Ante*, p 46.

or general welfare of the public,"[19] and that this "regulation" does not constitute a taking of private property because "[t]he members of BCBSM, unlike stockholders of a corporation, have no 'investment-backed expectations' in their unqualified right to control BCBSM" and because there has been no " 'physical invasion by *government'* over BCBSM's corporate direction" or *"governmental* 'taking' of BCBSM's property."[20]

The opinion of the Court does not state why the majority have concluded that the members of BCBSM do not have "investment-backed expectations" other than that BCBSM is a membership, rather than a stock, corporation. Presumably the distinction drawn by the majority rests on something more substantial than whether the interests of the incorporators and the successor members are embodied in a piece of paper called a stock certificate. Because the majority fails to state the basis of the distinction, I am left to surmise that they have concluded either that the members of BCBSM do not have an "investment" in BCBSM or an "expectation" that the Legislature would not eliminate their power to elect directors of their choice, or both.

B

Since the Legislature has never sought to transfer the control of any corporation, including of a membership corporation, from the persons in control to others and, as far as I can determine, this is without precedent in this country,[21] the members of BCBSM had a reasonable and substantial "expec-

[19] *Ante*, p 46.

[20] *Ante*, p 47.

[21] See *Board of Regents of the University of Maryland v Trustees of the Endowment Fund of the University of Maryland*, 206 Md 559, 569-571; 112 A2d 678 (1955), discussed in text accompanying n 23.

tation" that the Legislature would not eliminate their power to elect the overwhelming majority of the directors.

C

Before turning to the question whether the members of BCBSM had either an "investment" in BCBSM or an "investment-backed expectation," it should be noted that the United States Supreme Court has said "[t]here is no set formula to determine where regulation ends and taking begins." *Goldblatt v Town of Hempstead,* 369 US 590, 594; 82 S Ct 987; 8 L Ed 2d 130 (1962). Preceding the statement by the Court in *Penn Central Transportation Co v City of New York,* 438 US 104; 98 S Ct 2646; 57 L Ed 2d 631 (1978), that "the extent to which the regulation has interfered with distinct investment-backed expectations" is a "relevant consideration," the Court acknowledged that, in deciding whether a regulation will be deemed to be a noncompensable adjustment of the "benefits and burdens of economic life to promote the common good" or a compensable taking, it had engaged in "essentially ad hoc, factual inquiries." *Penn Central, supra,* p 124. In holding that a federal regulation requiring public access to a private marina adjoining navigable waters was a taking although the government could have refused to have allowed the dredging that made the marina navigable, the Court said it would not carry the "strict logic" of earlier decisions to their ultimate conclusion, and adverted to the observation of Justice Holmes "in a very different context" that "the life of the law has not been logic, it has been experience." *Kaiser Aetna v United States,* 444 US 164, 177, 179; 100 S Ct 383; 62 L Ed 2d 332 (1979). And in *Pennsylvania Coal Co v Mahon,* 260 US 393,

416; 43 S Ct 158; 67 L Ed 322 (1922), the Court said that because Takings Clause questions are "questions of degree" they "cannot be disposed of by general propositions."

Most of the Court's statements regarding the Takings Clause have been made, as in *Pennsylvania Coal Co, Goldblatt, Penn Central* and *Kaiser,* in cases challenging land use regulations. The question ordinarily is whether a regulation barring a land owner from exploiting some undeveloped aspect of his property—unmined coal in *Pennsylvania Coal Co, supra,* dredging and pit excavating in *Goldblatt,* air rights over Grand Central Station in *Penn Central* and the privacy of a marina in *Kaiser*—is a taking.

Act 350 does not seek to preclude the members of BCBSM from exploiting opportunities for changes in the bylaws or control of BCBSM not yet implemented—expectancies not yet exploited[22]—but rather seeks to transfer control of BCBSM, as it has developed as a result of prior exploitations. If the New York Legislature had sought to transfer control of Grand Central Station itself, surely a different result would have been reached in *Penn Central.*

A closer analogy than air rights over Grand Central Station is the marina in *Kaiser.* Although, as the Court acknowledged, the government might have barred the dredging of the marina or might have conditioned its approval of the dredging on compliance with various measures appropriate to the promotion of navigation, the body of water resulting from the dredging was private property

[22] The bylaws of BCBSM, approved by the Commissioner of Insurance, permit a majority of the directors to amend the bylaws and thus to reduce the number of representatives on the board of directors of "substantial group purchasers" of BCBSM coverage and representatives of labor unions having "substantial membership representatives" enrolled in BCBSM.

under Hawaii law and was linked to navigable water by a channel dredged with the consent of the government. The Court said that the " 'right to exclude,' so universally held to be a fundamental element of the property right, falls within this category of interests that the government cannot take without compensation." *Kaiser,* pp 179-180. So too here. The Legislature need not have exempted BCBSM from taxation, but, having done so, it cannot now belatedly exact a power to control BCBSM in exchange for the tax exemption.

D

Although most of the Takings Clause cases concern land use regulations, intangible personal property is property within the meaning of the Takings Clause. See *Armstrong v United States,* 364 US 40, 44; 80 S Ct 1563; 4 L Ed 2d 1554 (1960), holding that a materialman's lien was protected property. Nor is it determinative whether there has been a physical occupation of the property (see *Pennsylvania Coal Co* where the proscription of coal mining involved no physical occupation) or whether the state itself has taken over the property or directly benefited from the regulation. See *Loretto v Teleprompter Manhattan CATV Corp,* 458 US 419; 102 S Ct 3164; 73 L Ed 2d 868 (1982), holding that a law requiring landlords to allow cable television facilities on property was a taking, and *Kaiser,* holding that a regulation allowing the public to enter a private marina was a taking. The absence of a " 'physical invasion by *government*' " or of a "*governmental* 'taking' " in the sense of the state itself taking over BCBSM directly, is not determinative.

E

BCBSM, it is complained,[23] has excluded from its membership and board of directors representatives of subscribers other than the representatives of large corporate subscribers and large labor unions[24] with the result that small and medium-sized subscribers and senior citizens are unrepresented

[23] See ns 14-15 and accompanying text. Neither Act 350 nor any other act of the Legislature provides for the payment of just compensation for the taking of property resulting from the enactment of Act 350.

[24] BCBSM was organized under restated articles of incorporation as the successor of Michigan Hospital Service and Michigan Medical Service. Both prior corporations were organized under the 1939 enabling legislation, see n 33. Blue Cross was incorporated with $10,000, one-third of which amount was contributed each by Harper, Grace, and Ford Hospitals. Blue Shield was organized with some $16,000 contributed by the Michigan State Medical Society, an organization of physicians. Not surprisingly, representatives of the hospitals dominated the board of Michigan Hospital Service, and physicians dominated the membership and board of Michigan Medical Service, and, not surprisingly, once having obtained those positions, they have sought to retain the control they had at the outset.

In 1974, the two corporations were merged into the present BCBSM, and restated articles were filed stating in pertinent part that the present members of the corporation shall be persons named in accordance with the provisions of the plan of consolidation. Successor members shall be chosen in accordance with the bylaws. The articles further provide that the board of directors may adopt, amend, or alter the bylaws.

The bylaws provided for the present classification of membership, twenty-eight representatives of substantial group purchasers of Blue Cross and Blue Shield coverage, ten representatives of labor unions which have substantial membership segments enrolled in BCBSM, twelve consumers who shall be subscribers "influential in community affairs," four consumers named by the Commissioner of Insurance, fourteen doctors of medicine, four doctors of osteopathy, eighteen representatives of participating hospitals, two pharmacists, and the president of the corporation.

The board of directors consists of representatives of each class, but only half of the members of each class are directors. Thus, there are fourteen representatives on the board of directors of substantial group purchasers, five from labor unions which have substantial membership segments enrolled in BCBSM, six consumers influential in community affairs, two appointees of the Commissioner of Insurance, seven doctors of medicine, two doctors of osteopathy, nine representatives of hospitals, one pharmacist, and the president of the corporation ex officio.

or inadequately represented and the representatives of providers (hospitals and doctors) dominate BCBSM. In deciding whether the provisions of Act 350 that respond to that complaint by transferring the control of the business of BCBSM now shared by the representatives of providers and the large corporate subscribers and unions to representatives of the Governor and subscribers and providers not represented, is a regulation or a taking, we should bear in mind the admonition of the United States Supreme Court that "a State, by ipse dixit, may not transform private property into public property without compensation . . . ." *Webb's Fabulous Pharmacies, Inc v Beckwith*, 449 US 155, 164; 101 S Ct 446; 66 L Ed 2d 358 (1980). We should also have in mind Justice Holmes' observations in *Pennsylvania Coal Co, supra*, p 415, that "if regulation goes too far it will be recognized as a taking." When the regulation reaches "a certain magnitude, in most if not in all cases there must be an exercise of eminent domain and compensation to sustain the act. So the question depends upon the particular facts." *Id.*, p 413. "We are in danger of forgetting that a strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change. As we have already said, this is a question of degree—and therefore cannot be disposed of by general propositions. But we regard this as going beyond any of the cases decided by this Court." *Id.*, p 416.

F

This too goes "beyond any of the cases decided

Thus, of the forty-seven directors, nineteen are providers: the nine doctors, nine hospital representatives, and one pharmacist. Thus, if they vote together, they need only the votes of the president and four other persons to have a majority.

[by the United States Supreme Court]" or any other court except the Maryland Court of Appeals which struck down a statute purporting to transfer control of a corporation formed to act as trustee of an endowment funded for the benefit of a state university to the regents of that university. *Board of Regents of the University of Maryland v Trustees of the Endowment Fund of the University of Maryland,* 206 Md 559, 569-571; 112 A2d 678 (1955).[25]

G

We may assume, without deciding, that the proposed transformation of the governance of BCBSM is for a public use.[26] If it is not and there has been a taking, then Act 350 is invalid on that ground. We therefore need only decide whether the proposed transformation of the governance of BCBSM is a taking.

H

The property of nonprofit organizations and corporations is private property although the members, directors, and trustees of such organizations are obliged to use the property for the purpose for which the organization or corporation was organized and may not divert the property to their own personal benefit. The property of such an organization or corporation, no less so than the

[25] In *In re Mt Sinai Hospital,* 250 NY 103; 164 NE 871 (1928), the challenged legislation sought to preserve the control of the present directors of the hospital against possible interference by members who had no reasonable expectation of obtaining control and would only do so as a result of an unanticipated change in circumstances, a change in the method of financing public philanthropies.

[26] See n 1 and *Berman v Parker,* 348 US 26; 75 S Ct 98; 99 L Ed 27 (1954).

property of a profit corporation, is protected from an uncompensated taking for public use by the Takings Clause.

If the state, through the exercise of the power of eminent domain, purchases the property of a nonprofit corporation, the members and directors of the nonprofit corporation would, upon payment of just compensation for the going business value and other assets of the enterprise, be required to hold the proceeds as trustees to be used for the not-for-profit purpose for which the enterprise was organized.

I

Control of a corporation is a property interest[27] and therefore may not be appropriated by the state and transferred from the persons in control

[27] In *Board of Regents v Roth*, 408 US 564, 577; 92 S Ct 2701; 33 L Ed 2d 548 (1972), the United States Supreme Court said: "Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law. . . ." See also *Perry v Sindermann*, 408 US 593, 601; 92 S Ct 2694; 33 L Ed 2d 570 (1972); *Geriatrics, Inc v Harris*, 640 F2d 262, 264 (CA 10, 1981); *Baden v Koch*, 638 F2d 486, 489 (CA 2, 1980).

It is established state law that corporate control is a property interest that belongs to the corporation. See *Rowen v Le Mars Mututal Ins Co of Iowa*, 282 NW2d 639, 650 (Iowa, 1979); Berle, *The price of power: Sale of corporate control*, 50 Cornell L Q 628, 635 (1965); Bayne, *A philosophy of corporate control*, 112 U Pa L R 22, 50 (1963); Henn & Alexander, Laws of Corporations (3d ed), § 241, pp 656-661.

Corporate control is not always synonymous with ownership. "[Economists] see [corporate control] as a crucial element in the functioning of society's most important economic institution, the business firm. To them control means planning the firm's longterm strategy; allocating its resources; selecting products, markets, and technology; and making other key decisions." Werner, Book Review, 83 Colum L R 238, 239 (1983).

The stockholders of a stock corporation and the members of a membership corporation elect the directors or trustees of the corporation who, generally by majority vote, exercise that control.

to other persons without the payment of just compensation.[28]

J

I turn to a consideration of whether the rule is different where a nonprofit organization or corporation is involved on the ground that the members do not have an investment in the enterprise.

The present members of BCBSM are in the main the successors in interest of the persons who created the original constituent corporations in 1940 following the enactment of the enabling acts.[29]

One of the constituent corporations, Michigan Hospital Service, was organized with a cash contribution from three hospitals of $10,000, and the other, Michigan Medical Service, with a cash contribution of $16,000 from the Michigan State Medical Society. Without those cash investments and the volunteered labor of countless representatives of hospitals and the medical profession, BCBSM would not have grown as it has. That labor and money is an investment. Just as the person who endowed the corporation founded as a trustee of an endowment fund for the state university in *University of Maryland, supra,* had a constitutionally protected right and expectancy to choose the trustees and to provide for their succession, so too did the persons who created, and by their cash contributions and labors made Blue Cross and Blue Shield constituent corporations and BCBSM

[28] The concept that property cannot be taken by the state except upon payment of just compensation is "inherent in the definition of due process." Nowak, Rotunda & Young, Constitutional Law (2d ed), p 483, citing *Chicago, B & Q R Co v Chicago,* 166 US 226, 239; 17 S Ct 581; 41 L Ed 979 (1897), and *Webb's Fabulous Pharmacies, Inc v Beckwith,* 449 US 155, 160; 101 S Ct 446; 66 L Ed 2d 358 (1980).

See also Const 1963, art 10, § 2.

[29] See n 24.

valuable enterprises, so much so that the state would take them over rather than itself create a health care agency of state government.

Ordinarily, neither the members nor directors or trustees of a not-for-profit corporation have a personal financial interest in the business, property, income, or business of the organization or enterprise.[30] Most members, directors and trustees serve without any expectation of immediate personal financial gain and with little or no financial commitment other than annual payment of dues or subscriptions to further the purposes of the organization or enterprise along with others who are neither members, directors, nor trustees.

There are countless such voluntary associations, organizations, and enterprises. The reasoning of the Court might permit the Legislature to transfer control of those associations, organizations, and enterprises from the persons who organized them, gave them life, and through their efforts sustained them, to whomever the Legislature chooses to confer that power.

The majority says that this can be done "to promote the interests of all component groups [BCBSM] was designed to serve and to reduce the possibility of any one group gaining unassailable dominance over the corporation." This analysis would mean that the Legislature could change the governance of the United Foundation, a Michigan nonprofit corporation. The United Foundation, like BCBSM, subsists by reason of contributions made by hundreds of thousands, possibly millions, of persons. Some may think that it would be more

[30] Some members, directors or trustees may have made voluntary financial contributions to the organization. Others may have become salaried employees. Others may prosper through legitimate financial dealings with the orgainization. And still others may wield financial power by providing others with employment or authorizing contracts with providers of goods and services.

equitable if the directors were chosen by small contributors voting as a class electing some of the directors, medium-sized contributors electing another class of directors, and large-sized contributors electing still another class of directors, all pursuant to rules and regulations established and administered by a governmental functionary. Some might even think that it would be more equitable if the agencies served by the United Foundation, equivalent in a sense to the providers in the instant case, could also participate in the governance. There seems to be nothing in the Court's analysis of the Takings Clause which would preclude the Legislature from so transforming the governance of the United Foundation. Auto Club Insurance Association, formerly Detroit Automobile Inter-Insurance Exchange, is a voluntary association which has been dominated for many years by persons who are the successors of those who organized that enterprise. Auto Club, like BCBSM, has been subjected to regulation by the Commissioner of Insurance with regard to some of its underwriting practices. Under the Court's analysis, the Legislature could by fiat transform the governance of Auto Club, allow the Governor to appoint members to its Board of Governors, and take over the process by which the Governors of the Auto Club are elected so that no one group may continue to exercise "unassailable dominance" of that association and insureds are adequately represented and have adequate input into the rate structure, the underwriting of risks and the payment of claims.

Further, (i) the "substantial group purchasers" (Chrysler Corporation [which filed a brief amicus curiae], Ford Motor Company, General Motors Corporation, Michigan Farm Bureau, Michigan Bell Telephone Company and The Bendix Corpora-

tion), each of which corporations have one representative on the board of directors and one additional representative in the membership of BCBSM, and (ii) the unions (the UAW has three directors and three additional members, the AFL-CIO two directors and one additional member) and (iii) the other large purchasers of BCBSM coverage represented on the board of directors or in the membership (Michigan National Corporation, Ex Cell-O Corporation, Burroughs Corporation, National Bank of Detroit, Dana Corporation, Crowley, Milner & Company), may have investment-backed expectations resulting from expenditures of money and energy to develop prepaid health care contracts with BCBSM providing the coverage they desire and assurances of continuing good relationships with BCBSM resulting from participation in its membership and board of directors and the influence they may thereby exert.

A principal component of the going business value of BCBSM is its capacity to administer a system of financing and payment for health care services between subscribers and providers on a state-wide basis, at levels of quality established by subscribers and providers, to the extent they influence BCBSM decisions, in competition with whatever level of quality is or would be provided under commercially insured prepaid health care plans. That capacity and going business value is the result of an investment of money and labor and is property of value to the corporate and union users and the providers, whose representatives in the membership and on the board of directors of BCBSM do indeed dominate BCBSM.

I am not now questioning the power of the Legislature to decide upon the manner in which the governance of organizations such as BCBSM, United Foundation, and Auto Club, shall be deter-

mined.[31] All three are supported and thrive only because of contributions and payments by hundreds of thousands or millions of persons who may not have an effective voice in the governance of those enterprises. The socialization or democratization—choose your idiom—of such organizations may be in the public interest. That is indeed a legislative not a constitutional question.

K

The opinion of the Court asserts that BCBSM has always been subject to intrusive governmental regulation. In actuality, it has been subject to limited regulation. In *Blue Cross & Blue Shield of Michigan v Ins Comm'r,* 403 Mich 399; 270 NW2d 845 (1978), this Court said, in effect, that the Commissioner of Insurance had only limited regulatory power.[32] He had no power with regard to physician's fees, and the only power that we recognized with regard to hospital charges was the

[31] Detroit Edison and Consumers Power in contrast with BCBSM are quasi-public corporations. See *Wenham v Dep't of Public Utilities,* 333 Mass 15, 16; 127 NE2d 791 (1955). Both Detroit Edison and Consumers Power have been intrusively and vigorously regulated.

Although no one would question that their stockholders have distinct investment-backed expectations, it might not have an immediate or long-range adverse effect on the value of the common stocks of Comsumers Power or Detroit Edison if the Governor were to be empowered to make his political appointees members of the board of directors and allow customers by classes, large, small, medium users, to elect still other directors. In this manner, "all component groups" that Consumers and Detroit Edison "were designed to serve" would be represented more equitably.

Again, I do not question the power of the Legislature to enact laws concerning the governance of private corporations whether they be profit or nonprofit corporations. It is a separate issue, however, whether such a law transforming the governance of a private profit or nonprofit association, corporation, or enterprise constitutes a taking of private property.

[32] See *Westland Convalescent Center v Blue Cross & Blue Shield of Michigan,* 414 Mich 247, 280-282; 324 NW2d 851 (1982) (LEVIN, J., *concurring).*

power to eliminate charges that would result in waste.

Nor is it true that the original 1939 enabling acts conferred any significant power on the Attorney General or the Commissioner of Insurance regarding the governance of the Blue Cross and Blue Shield constituent corporations. While the 1939 enabling acts requires that the articles of association be submitted to the Attorney General for his examination, they also provided that if he found the articles "to be in compliance with this act, he *shall* so certify to the Commissioner of Insurance."[33] The Attorney General thus was not empowered to require provisions such as those contained in Act 350 regarding the distribution of the power of governance of Blue Cross or Blue Shield. Michigan Hospital Service was required to have representation from the public, hospitals, and the medical profession on its board of directors,[34] and the Michigan Medical Service to have representatives of the public and the medical profession on its board.[35] It appears that the Attorney General and the Insurance Commissioner were satisfied that those requirements were complied with by, and therefore mean no more than, a board of directors consisting of between twenty and thirty percent nonproviders for Michigan Hospital Service and less than fifteen percent for Michigan Medical Service.

There was no requirement that those public members be representatives of the subscribers or indeed that they be subscribers.

The 1974 amendments, concerning the merger of the constituent corporations, also provided for representation from the "public, the medical profes-

[33] MCL 550.304; MSA 24.594.

[34] MCL 550.502; MSA 24.622.

[35] MCL 550.308; MSA 24.598.

sion, and the participating hospitals . . . ."[36] The Commissioner of Insurance was given the power to disapprove the plan of merger or consolidation, but only upon designation of those provisions of the proposed plan or merger or consolidation that did not satisfy the requirements of the amendatory act. Provision was also made for judicial review of such disapproval by the Ingham Circuit Court, and the question was narrowed to whether the plan satisfied the requirements of the amendatory act. Clearly, the Commissioner of Insurance, just as the Attorney General, was denied discretion. There is still other language stating that the articles may be amended "with the approval of the Commissioner of Insurance" but it is stated that she may do so in any manner "not inconsistent with the provisions of this act."[37]

The Legislature thus circumscribed and limited the power of the commissioner and Attorney General to disapprove the provisions of the articles. The statements in the opinion of the Court to the effect that BCBSM has always been subject to intrusive governmental regulation ignore the limitations on the commissioner's power spelled out in the enabling acts and recognized by this Court in *Blue Cross.* Indeed, the Court's analysis or characterization of the history of regulation of BCBSM is inconsistent with the reason why we are here today. If the commissioner or the Attorney General had significant power there would have been no need to enact Act 350. It is because they did not have power that Act 350 was enacted. The Court seeks to justify radical legislation on the

[36] MCL 550.309a; MSA 24.599(1).

[37] MCL 550.304; MSA 24.594.

The Michigan Hospital Service Corporation enabling act does not contain the "not inconsistent with the provisions of the act" language. MCL 550.305; MSA 24.595.

basis that there is no substantial change or enlargement of the degree of regulation although the Legislature would have had no occasion to enact Act 350 to bring about no substantial change. The majority cannot justifiably excuse or ignore the challenges of BCBSM on the basis that there is no substantial change.

In light of the foregoing history, it cannot properly be said that the organizers of the BCBSM constituent corporations and of BCBSM and the members thereof should have anticipated that the Legislature might seek to so transform the governance of BCBSM.

III

BCBSM challenges the constitutionality of provisions of Act 350 on the grounds that they impair the obligation of contract,[38] deprive BCBSM of property without due process of law[39] and of the equal protection of the laws,[40] and constitute an unconstitutional delegation of legislative authority.[41]

I conclude that the provision(s) of Act 350 that

(1) Transfer from the present members of BCBSM to BCBSM subscribers and others the power to select the members[42] and the directors[43] of BCBSM, and from the members to the newly constituted board of directors the powers to amend the articles of incorporation[44] and bylaws,[45] and that expand the purposes of the corporation to include provid-

[38] Const 1963, art 1, § 10.

[39] Const 1963, art 1, § 17. See also US Const, Am XIV.

[40] Const 1963, art 1, § 2.

[41] Const 1963, art 4, § 1. See also US Const, Am XIV.

[42] MCL 550.1305; MSA 24.660(305). See n 17 for text.

[43] MCL 550.1301; MSA 24.660(301). See n 13 for text.

[44] MCL 550.1202-550.1203; MSA 24.660(202)-24.660(203).

[45] MCL 550.1302; MSA 24.660(302).

ing subscribers "reasonable access to, and reasonable cost and quality of, health care services" and achieving the statutory goals "relative to access, quality and cost of health care services,"[46] that impose on directors a fiduciary obligation to BCBSM subscribers as well as to BCBSM[47] and that provide, upon a dissolution of BCBSM, for the escheat to the state of its assets,[48] are violative of the Due Process Clause;

(2) Provide for a panel of three actuaries to review risk factors disapproved by the Commissioner of Insurance,[49] and provide for the appointment of retired circuit court judges[50] to review disapprovals by the commissioner of provider class plans and other appeals arising under part 5 of the act[51] are invalid because they constitute an unconstitutional delegation of legislative authority;

(3) Impose limitations on BCBSM with respect to administrative services only (ASO) contracts[52] different from those imposed on commercial prepaid health insurers[53] are violative of the Equal Protection Clause, and the provisions that impose limitations on BCBSM with respect to packaging life insurance[54] different from those imposed on com-

[46] MCL 550.1202(d); MSA 24.660(202)(d). See n 65 for text.

[47] MCL 550.1310; MSA 24.660(310). See n 66 for text.

[48] MCL 550.1217; MSA 24.660(217). See n 67 for text.

[49] MCL 550.1205(5), (6); MSA 24.660(205)(5), (6). See n 71 for text.

[50] MCL 550.1514; MSA 24.660(514). See n 78 for text.

[51] MCL 550.1515; MSA 24.660(515). See also MCL 550.1501; MSA 24.660(501), MCL 550.1502(7); MSA 24.660(502)(7), MCL 550.1508; MSA 24.660(508), MCL 550.1516; MSA 24.660(516), MCL 550.1518; MSA 24.660(518).

[52] MCL 550.1211; MSA 24.660(211).

[53] MCL 550.5208; MSA 24.15208, MCL 500.5208(a); MSA 24.15208(1). See also MCL 500.3425; MSA 24.13425, MCL 500.3609a; MSA 24.13609(1).

[54] MCL 550.1206(4); MSA 24.660(206)(4).

mercial prepaid health insurers[55] may be violative of the Equal Protection Clause;

(4) Bars BCBSM from limiting or denying coverage or reimbursement on the ground that services were rendered while the subscriber was in a health care facility operated by the state[56] is valid, but the provision requiring BCBSM to accord participation status to such a health care facility[57] is violative of the equal protection component[58] of the Due Process Clause;

(5) Empower the commissioner to issue a cease and desist order and exact a fine on a finding of probable cause[59] and authorize the commissioner to suspend BCBSM's certificate of authority summarily without a hearing[60] are violative of the Due Process Clause;

(6) Requires BCBSM to offer to all residents of the state the opportunity to become a subscriber,[61] although somewhat ambiguous, is not facially unconstitutional;

(7) Requires BCBSM to provide an informal procedure for subscriber complaints[62] and requires BCBSM to submit new or revised subscriber certificates to the commissioner for approval[63] is not unconstitutional;

(8) Requires BCBSM to reincorporate under Act

[55] No provision of the Insurance Code bars or limits a commercial prepaid health insurer from marketing both health and life insurance.

[56] MCL 550.1401(7); MSA 24.660(401)(7). See n 89 for text.

[57] See n 56.

[58] Const 1963, art 1, § 17. 16A Am Jur 2d, Const Law, § 816, p 978. See also 16A Am Jur 2d, Const Law, §§ 740-741, pp 782 *ff.*

[59] MCL 550.1402(7), (8); MSA 24.660(402)(7), (8).

[60] MCL 550.1605(2); MSA 24.660(605)(2).

[61] MCL 550.1401(1); MSA 24.660(401)(1). See n 95 for text.

[62] MCL 550.1404; MSA 24.660(404).

[63] MCL 550.1607(1); MSA 24.660(607)(1).

350[64] is unconstitutional because of the constitutional infirmities in the act.

The question whether the valid provisions of Act 350 are severable and enforceable has not been briefed and should be remanded to the circuit court for briefing and decision. We should retain jurisdiction.

IV

The corporate purposes of BCBSM, which was organized to provide a means of *financing* payment for health care benefits, are enlarged by the act to impose on BCBSM the corporate obligations

(i) to provide residents of this state and subscribers the opportunity for "reasonable access to, and reasonable cost and quality of, health care services," and

(ii) to achieve the statutory goals of providing the state with a health care system that assures residents and subscribers such access to health care services with

(a) "an appropriate number of providers throughout this state,"

(b) providers that meet and abide by reasonable standards of health care quality, and

(c) a rate of change in reimbursement "to each provider class" that is not higher "than the compound rate of inflation and real economic growth."

BCBSM was organized to provide a means of financing payment for health care services, not to provide health care.[65] BCBSM is not a provider. It

[64] See n 12.

[65] "(d) The purposes of the corporation, which shall be:

"(i) To provide health care benefits.

"(ii) To secure for all of the people of this state who apply for a certificate, the opportunity for access to coverage for health care services at a fair and reasonable price.

cannot, consistent with the Due Process Clause, be required either

(i) to devote its assets to a business which it does not freely enter, or

(ii) to develop and police a quality health care system with an adequate number of providers who both meet and abide by reasonable standards established by it or by the commissioner or, on appeal, by a retired circuit court judge, and who are willing to accept as compensation remuneration subject to a rate of change in reimbursement that does not exceed "the compound rate of inflation and real economic growth."

BCBSM, although the largest prepaid health carrier, does not have a monopoly of the prepaid health care market. It is in competition with the commercial prepaid health insurers.

The state might seek to develop and police a health care system that seeks to establish standards for providers and to control their compensation at levels of service determined by the state. Such legislation might be valid. The state would then have assumed the responsibility for providing and achieving the goals of assuring all residents of the state, or all who are willing and able to prepay for health care services, "reasonable access to, and reasonable cost and quality of, health care ser-

"(iii) To assure for nongroup and group subscribers, *reasonable access to, and reasonable cost and quality of, health care services.*

"(iv) To *achieve the goals of the corporation relative to access, quality, and cost of health care services,* as prescribed in section 504. . . ." MCL 550.1202(d); MSA 24.660(202)(d). (Emphasis supplied.)

See n 72 for the text of § 504.

The original enabling acts provided that the articles of incorporation shall state "the purposes of corporations." MCL 550.303; MSA 24.593, MCL 550.504; MSA 24.624.

The restated articles of incorporation of BCBSM state that its purpose is to "exercise all of the power" of a medical care corporation organized under 1939 PA 108 and of a hospital service corporation organized under 1939 PA 109.

vices," "an appropriate number of providers throughout the state," and that providers "meet and abide by reasonable standards of health care quality" and none are compensated at a rate of change in reimbursement higher "than the compound rate of inflation and real economic growth."

All prepaid health carriers would, assuming the constitutionality of such legislation, then be prohibited from reimbursing providers at a higher rate and providers would be prohibited from accepting more than the state established level of reimbursement. It would then be the state's responsibility to police the system.

The burden sought to be imposed on BCBSM would deny it due process of law and the equal protection of the laws. BCBSM cannot be required to undertake alone to provide health care services to subscribers or residents of this state or to achieve a lower rate of reimbursement and the other goals of the legislation.

V

The act also provides that the directors of BCBSM have a fiduciary obligation to the subscribers of BCBSM as well as to BCBSM,[66] and that, upon a dissolution of BCBSM, its assets shall escheat to the state.[67]

As set forth in part II-H, upon a dissolution of

[66] "Sec. 310. (1) With respect to management of the affairs and property of the health care corporation, and in the selection, supervision, and control of committees of the board, employees of the health care corporation, and officers, each director and officer, and the composite board, shall exercise the duties of a fiduciary toward the health care coporation *and the subscribers* of the health care corporation as a whole, and shall discharge his or her duties with the degree of diligence, care, and skill which an ordinarily prudent person would exercise under the same or similar circumstances in a like position." MCL 550.1310; MSA 24.660(310). (Emphasis supplied.)

[67] "Sec. 217. Upon dissolution of a helath care corporation, the assets remaining after the payment of all debts of the corporation

BCBSM, its properties would be required to be held and used by the members and directors as trustees for the not-for-profit purpose for which BCBSM was organized, and accordingly are not subject to confiscation by escheat.

The fiduciary obligation of BCBSM directors to BCBSM and the fiduciary obligation sought to be imposed by Act 350 on its directors for the benefit of BCBSM subscribers[68] are in conflict. Requiring directors of BCBSM to serve two masters deprives BCBSM of the undivided loyalty of its directors in violation of the Due Process Clause.

Similarly, minutes of meetings of the directors of BCBSM are property which BCBSM may not be required to disclose except for limited purposes.[69]

The foregoing conclusions make it unnecessary to reach BCBSM's Contract Clause claims.

VI

I agree with the majority[70] that the provisions of the act conferring on three actuaries the power to resolve risk factors disputes[71] constitute an unlaw-

shall escheat to the state." MCL 550.1217; MSA 24.660(217). (Emphasis supplied.)

[68] See n 67.

[69] Although minutes are property, disclosure might be required to the Commissioner of Insurance or in a lawsuit where the subject covered by the minutes are relevant. Act 350 goes further, however, in making them generally available to subscribers and, thus, readily available to a competitor of BCBSM. MCL 550.1304; MSA 24.660(304).

[70] *Ante*, p 96.

[71] "(5) Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

"(a) Approve the factors and proceed under subsection (7).

"(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. The corporation shall then have 60 days to submit a risk factor for each line of business defined by either the commissioner or the corporation, which shall be approved or disapproved by the commissioner under

ful delegation of legislative power under the circumstance that no standard is stated to guide the commissioner in the exercise of the power confided to her with the result that the actuaries are also without guidance.

VII

The provisions of part 5 of the act concerning provider plans also constitutes an unlawful delegation of legislative power to the commissioner and the hearing officers. The goals of an "appropriate number of providers," "reasonable standards of health care quality" and compensation of providers at a rate of change in reimbursement "that is not higher than the compound rate of inflation and real economic growth"[72] coupled with the re-

this subsection. A health care corporation may revise a previously filed risk factor under this subsection.

"(c) Disapprove the factors, and proceed under subsection (6).

"(6) If the risk factors are disapproved by the commissioner pursuant to subsection (5)(c), the commissioner shall immediately notify the health care corporation of the disapproval. Within 6 months following notification, a panel of 3 actuaries, 1 appointed by the commissioner, 1 by the corporation, and 1 appointed by the 2 previously appointed actuaries, shall determine a risk factor for each line of business. The agreement of any 2 actuaries on the panel shall be sufficient for the determination of the risk factors, and the panel shall transmit a copy of the risk factors to both the commissioner and the corporation." MCL 550.1205; MSA 24.660(205).

[72] "Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following *goals:*

"(a) There will be an *appropriate number of providers* throughout this state to assure the availability of certificate-covered *health care services* to each subscriber.

"(b) Providers will meet and abide by reasonable standards of health care quality.

"(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than *the compound rate of inflation and real economic growth.*

"(2) As used in this section:

quirements that there be "responsible cost controls" that "balance quality, accessibility and costs"[73] are undefined. There are no precedents or guides to limit the exercise of discretion. The

---

"(a) 'Gross national product in constant dollars' means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

"(b) 'Implicit price deflator for gross national product' means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

"(c) 'Inflation' or 'I' means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.

"(d) 'Compound rate of inflation and real economic growth' means the ratio of the quanity '100 plus inflation', multiplied by the quantity '100 plus real economic growth', to 100; minus 100; or as expressed in the following formula:

$$\left\{\frac{(100 + I) \times (100 + REG)}{100}\right\} - 100$$

"(e) 'Rate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination.

"(f) 'Real economic growth' or 'REG' means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

"(3) Nothing in this section shall preclude efforts by a health care corporation supplemental to the goals prescribed in subsection (1)." MCL 550.1504; MSA 24.660(504).

[73] "Sec. 516. (1) All provider class plans retained by the commissioner under section 513 or approved by the hearing officer shall maintain the following standards for all providers:

"(a) Responsible cost controls shall exist that balance quality, accessibility, and cost.

"(b) The health care corporation shall promote programs and policies which encourage cost-effective behaviour by providers in accordance with the provisions of this act, and in accordance with all of the following:

"(i) There shall be a reasonable basis for believing that the programs will be effective.

"(ii) The programs applicable to a provider class shall be reviewed to avoid duplication or inconsistency, to the extent practicable." MCL 550.1516; MSA 24.660(516).

ultimate decisional authority is vested in a retired circuit judge. The retired judge-hearing officer is empowered to decide that a provider class plan shall not be retained whereupon the commissioner may suspend or limit BCBSM's certificate of authority until BCBSM submits a provider class plan that "the hearing officer determines should be retained."[74]

The retired judge-hearing officers are not full-time governmental officials; here, in contrast with *Detroit v Detroit Police Officers Ass'n*, 408 Mich 410; 294 NW2d 68 (1980),[75] there is no standard of comparable wages, hours or conditions of employment and traditional practices[76] to guide and limit

[74] "(5) After receipt of a provider class plan transmitted by the health care corporation pursuant to subsection (4), the hearing officer shall determine 1 of the following:

"(a) That the provider class plan prepared by the corporation shall be retained as provided in section 506(4).

"(b) That the provider class plan prepared by the corporation should not be retained as provided in section 506(4), and the commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the hearing officer determines should be retained as provided in section 506(4)." MCL 550.1515(5); MSA 24.660(515)(5).

[75] In this case, the Court held Act 312, concerning compulsory arbitration of labor disputes in police and fire departments, to be constitutional; I adhere to the views there expressed in dissent.

[76] "Sec. 9. Where there is no agreement between the parties, or where there is an agreement but the parties have begun negotiations or discussions looking to a new agreement or amendment of the existing agreement, and wage rates or other conditions of employment under the proposed new or amended agreement are in dispute, the arbitration panel shall base its findings, opinions and order upon the following factors, as applicable.

• • •

"(d) Comparison of the wages, hours and conditions of employment of the employees involved in the arbitration proceeding with the wages, hours and conditions of employment of other employees performing similar services and with other employees generally:

"(i) In public employment in comparable communitites.

"(ii) In private employment in comparable communities.

"(e) The average consumer prices for goods and services, commonly known as the cost of living.

• • •

the exercise of discretion. Here there is neither comparability nor tradition because the concept of authorizing one prepaid health carrier or a commissioner of insurance or a retired judge-hearing officer to formulate health care policy for the state to achieve such conflicting goals through the mechanism of controlling the rates of payments by one prepaid health carrier to providers without the involvement of any other prepaid health carrier or the providers is unprecedented.

The concept is further flawed in involving the State Court Administrator. I agree with the majority[77] that the Legislature intended that the State Court Administrator would exercise some discretion in compiling the list of retired judges[78] and would have the power to exclude from the list judges whose performance was regarded as unsatisfactory. This means that the State Court Administrator, a person appointed by and who serves at the pleasure of this Court,[79] would be involved in

"(h) Such other factors, not confined to the foregoing, which are normally or traditionally taken into consideration in the determination of wages, hours and conditions of employment through voluntary collective bargaining, mediation, fact-finding, arbitration or otherwise between the parties, in the public service or in private employment." MCL 423.239; MSA 17.455(39).

[77] *Ante*, pp 55, 56.

[78] "Sec. 514. (1) All appeals under this part shall be held before an independent hearing officer. The state court administrator shall compile and maintain a list of individuals possessing all of the following qualifications:

"(a) Is a retired circuit court judge.

"(b) Is a resident of this state.

"(c) Is not engaged in the provision of health care services.

"(d) Is not an officer or employee of a health care provider, health care corporation, or an employee of this state. For purposes of this subdivision, an employee of an educational institution shall not be considered to be employed by this state.

"(2) The hearing officer shall be selected at random by the commissioner from the list described in subsection (1), on a per appeal basis. If the individual selected is performing judicial duties, another individual shall be selected." MCL 550.1514(1), (2); MSA 24.660(514)(1), (2).

[79] Const 1963, art 6, § 3; GCR 1963, 901.

the selection of hearing officers, thereby cloaking the decision reached by the hearing officer with the imprimatur of this Court's authority and possibly embarrassing further review by the Court of Appeals[80] or this Court.[81] While retired judges may become hearing officers, this Court should not be involved, however indirectly, in the selection process.[82]

Since the provisions concerning professional health care providers[83] are subject to the invalid appeal procedure they too are unenforceable.

The foregoing conclusions make it unnecessary to reach BCBSM's Contract Clause claims.

VIII

An ASO contract is an arrangement whereby a prepaid health carrier provides an employer who desires to be self-insured with administrative services only for a fee; the prepaid health carrier agrees to treat employees of the self-insured employer as if they were subscribers and to pay their providers and thus assumes the risk that the self-insured employer may not be able to reimburse the prepaid health carrier for expenditures to providers for employees of the self-insured employer. The Insurance Code, accordingly, imposes limitations on such arrangements,[84] but Act 350 imposes more onerous limitations on BCBSM[85] than on commercial prepaid health carriers.

---

[80] MCL 550.1518; MSA 24.660(518).

[81] Const 1963, art 6, § 4; GCR 1963, 851.

[82] Const 1963, art 6, § 1, § 4; art 3, § 2.

[83] MCL 550.1502; MSA 24.660(502).

Paragraph (7) of § 502 provides that "[c]ontracts entered into under this section shall be subject to the provisions of sections 504 to 518."

[84] See n 53.

[85] See n 52.

I agree with the majority[86] that the ASO limitations set forth in Act 350 deny BCBSM the equal protection of the laws.

IX

Act 350 bars BCBSM from marketing life insurance with BCBSM coverage.[87] Such dual marketing is called packaging and is especially attractive to relatively small employers who thereby reduce the number of their insurance relationships and the time they expend in purchasing insurance coverages.

Since 1979, BCBSM sales representatives have marketed packages of BCBSM coverage and life insurance underwritten by American Bankers Life Assurance Company of Florida. BCBSM has no underwriting risk and thus there is no violation of the BCBSM enabling acts.

BCBSM receives no compensation from ABL. BCBSM sales representatives, however, do receive slaes commissions from ABL for life insurance sold and BCBSM is able to sell BCBSM coverage that it would not otherwise be able to sell.

It appears that a purpose of this legislation is to protect independent life insurance salesmen from the competition of packaging by BCBSM of health and life insurance. It is not claimed that providing protection from competition to a favored group is itself a legitimate basis for exercise of the police power.[88] It is rather claimed that it is necessary to bar competition to preserve competition; the predicate of that rationale is that BCBSM/ABL packaging will ultimately reduce competition in the life in-

[86] *Ante*, p 96.

[87] See n 54.

[88] *Cf. Arlan's Dep't Stores, Inc v Attorney General*, 374 Mich 70, 74-75; 130 NW2d 892 (1964) (opinion of ADAMS, J.).

surance market and reduce the number of life insurers who offer prepaid health insurance. That predicate is of doubtful factual content.

The largest life insurers, and there are quite a number in that category, are financial giants, and BCBSM, by comparison, is a financial pigmy. Life insurers are likely to remain in the prepaid health insurance business as long as it is profitable. Be that as it may, there has been adequate experience in this and other states with packaging so that it should now be possible to determine whether there is sufficient substance to the proffered bar-competition-to-preserve-competition rationale to provide a rational basis for the classification. I would remand to the circuit court for further findings thereon.

X

The first sentence of § 401(7) of the act[89] barring BCBSM from limiting or denying coverage to a

[89] "(7) A health care corporation shall not limit or deny coverage to a subscriber or limit *or deny reimbursement to a provider* on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit *or deny participation status* to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

"(a) Be accredited by the joint commission on accreditation of hospitals.

"(b) Meet the certification standards of the medicare program and the medicaid program.

"(c) Meet all statutory requirements for certificate of need.

"(d) Follow generally accepted accounting principles and practices.

"(e) Have a community advisory board.

"(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

"(g) Designate that portion of the facility which is to be used for acute care." MCL 550.1401(7); MSA 24.660(401)(7).

subscriber limiting or denying reimbursement to a provider on the ground that the service was rendered while the subscriber was in a health care facility operated by the state or a political subdivision of this state parallels the provisions of § 2237[90] of the Insurance Code. This provision thus only imposes on BCBSM an obligation similar to that already imposed on commercial insurers and, therefore, is not violative of the Equal Protection Clause.

The second sentence, however, bars BCBSM from limiting or denying participation status to such a facility. This goes beyond what has been imposed on commercial insurers by requiring BCBSM's subscribers to pay for a level of reimbursement to the state not required of commercially insured subscribers. The second sentence denies BCBSM and its subscribers equal protection of the laws.

XI

I agree with the majority for the reasons stated by them[91] that the provisions of the act that empower the commissioner to issue a cease and desist order on a finding of probable cause[92] denies BCBSM the equal protection of the laws. I also agree that the provision of the act that permits the commissioner to suspend summarily without a hearing[93] BCBSM's certification of authority deprives it of due process of law.

XII

I agree with the majority[94] that the provisions of

[90] MCL 500.2237; MSA 24.12237.

[91] *Ante*, p 90.

[92] See n 59.

[93] See n 58.

[94] *Ante*, pp 24, 26.

the act that require BCBSM to offer the opportunity to all residents of the state to become subscribers of BCBSM,[95] although somewhat ambiguous, are not facially unconstitutional.

The provisions of the act requiring the commissioner to establish an informal procedure for subscriber complaints[96] and requiring BCBSM to submit new or revised subscriber certificates to the commissioner for approval[97] appear to parallel similar regulation of commercial insurers and are constitutional.

XIII

Because of the fundamental infirmities in Act 350, especially the provisions transferring control of BCBSM from its members to subscribers, providers and appointees of the Governor, the provision of Act 350 requiring BCBSM to reincorporate under Act 350[98] is invalid.

The parties have not briefed the question whether the valid provisions of Act 350 are severable and may govern BCBSM although it remains incorporated under 1939 PA 108 and 109. The cause should be remanded to the circuit court for briefing, argument and decision thereon. I would retain jurisdiction.

Justice RILEY took no part in the decision of this case.

---

[95] "Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner." MCL 550.1401(1); MSA 24.660(401)(1).

[96] See n 62.

[97] See n 63.

[98] See n 64.

Ingham County Circuit Court Order of Preliminary Injunction, April 2, 1981

STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF INGHAM
File No. 81-26748-CZ

BLUE CROSS and BLUE SHIELD OF MICHIGAN,
a non-profit Michigan Corporation,
Plaintiff,

—vs.—

WILLIAM G. MILLIKEN, GOVERNOR OF THE STATE OF MICHIGAN, FRANK J. KELLEY, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, and NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,
Defendants.

ORDER

At a session of said Court held in the City of Lansing, Michigan, this 2nd day of April, 1981.

Present: HON. JACK W. WARREN, *Circuit Judge.*

Plaintiff having petitioned this Court for preliminary injunction restraining Defendants, their agents and servants, from enforcing the provisions of Act 350 of the Public Acts of 1980, as amended by Act 430 of the Public Acts of 1980, which Act is scheduled to become effective April 3, 1981; and Plaintiff having set forth in its brief numerous claims of unconstitutionality, which claims require careful study and analysis; and it appearing that additional time is required by this Court not only to carefully weigh the contentions of Plaintiff, but also to carefully weigh arguments in opposition; and the Court having

considered the profound effects of this legislation; now therefore, it is

ORDERED as follows:

(1) The Defendants, their agents and servants, are enjoined and restrained from enforcing the provisions of said Act, as amended, until further order of this Court.

(2) Counsel for Defendants shall be permitted to file supplemental brief.

(3) The Court will receive and consider briefs from counsel for Michigan State Life Underwriters Association and Michigan Citizens Lobby if the same be submitted on or before 5:00 p.m., April 24, 1981.

(The foregoing Order is not to be taken as any determination on the merits.)

/s/ JACK W. WARREN

Jack W. Warren, *Circuit Judge*

Ingham County Circuit Court Order of Preliminary Injunction, July 31, 1981

STATE OF MICHIGAN
THE CIRCUIT COURT FOR THE COUNTY OF INGHAM

File No. 81-26748-CZ

BLUE CROSS and BLUE SHIELD OF MICHIGAN, a non-profit Michigan corporation,

Plaintiff,

—vs.—

WILLIAM G. MILLIKEN, GOVERNOR OF THE STATE OF MICHIGAN, FRANK J. KELLEY, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, and NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

At a session of said Court, held in the City of Lansing, Michigan this 31st day of July, 1981.

Present: HON. JACK W. WARREN, *Circuit Judge*.

This Court having on April 2, 1981, in relation to Public Act No. 350 of the Public Acts of 1980, as amended, entered an order reading in part as follows:

> "(1) The Defendants, their agents and servants, are enjoined and restrained from enforcing the provisions of said Act, as amended, until further order of this Court."; and

It appearing that irreparable harm may result if this Court does not direct the parties in certain respect; now therefore, it is,

ORDERED, as follows:

(1) Plaintiff and Defendants shall be, and hereby are, restrained and enjoined from taking any action to implement, enforce, or otherwise apply or give effect to the repealer provisions of Section 703 of P.A. 350, Public Acts of 1980, as amended, pending further order of this Court; and

(2) Plaintiff and Defendants shall be, and are hereby ordered to implement, enforce, comply with, and otherwise apply and give effect to P.A. 108, Public Acts of 1939, as amended, and P.A. 109, Public Acts of 1939, as amended, pending further order of this Court.

/s/ JACK W. WARREN

Jack W. Warren, *Circuit Judge*

Michigan Supreme Court Order Directing Circuit Court to Certify Controlling Questions of Public Law, March 25, 1982

AT A SESSION OF THE SUPREME COURT OF THE STATE OF MICHIGAN, Held at the Supreme Court Room, in the City of Lansing, on the 25th day of March in the year of our Lord one thousand nine hundred and eighty two.

CR 37-51, CR 37-51a, CR 37-51b, CR 37-79,
CR 37-79a, CR 37-79b, CR 37-79c, CR 37-79d

Present the Honorable

MARY S. COLEMAN,
Chief Justice.

THOMAS GILES KAVANAGH,
G. MENNEN WILLIAMS,
CHARLES L. LEVIN,
JOHN W. FITZGERALD,
JAMES L. RYAN,
BLAIR MOODY, JR.,
Associate Justices.

SC: 68876, CoA: 62426, LC: 82-28745

COMMISSIONER OF INSURANCE,
Plaintiff-Appellant,

—v.—

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a consolidated medical care and hospital service corporation,
Defendant-Appellee.

SC: 68903, LC: 81-26748

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
a non-profit Michigan corporation,
Plaintiff,

—v.—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

On February 25, 1982, this Court granted leave to appeal in these matters, directing that they be argued and submitted together on March 5, 1982. On March 3, 1982, this Court vacated that portion of the February 25, 1982, order which provided for oral arguments and a briefing schedule in the case of *Blue Cross and Blue Shield of Michigan* v. *Governor of the State of Michigan, et al.* (Docket No. 68903). Blue Cross and Blue Shield of Michigan had consented to the entry of an order restraining it from taking certain actions pursuant to a rate increase effective February 1, 1982 (the "rate increase"), and this Court ordered that Blue Cross and Blue Shield of Michigan could not, before April 5, 1982, (1) take any action to require payment by any subscriber of the rate increase, (2) cancel or terminate any subscriber because the subscriber had failed to pay the rate increase, or (3) cancel or terminate any subscriber for failure to pay the premium due February 1, 1982, before giving the subscriber 10 days' written notice that the subscriber need only pay the amount of the premium applicable before the rate increase. The March 3, 1982 order further directed Blue Cross and Blue Shield of Michigan to notify former subscribers whose individual line coverage had lapsed or been cancelled since February 1, 1982, that the coverage may be reinstated by paying the charges due according to the rates in effect before the rate increase by March 15, 1982.

The Court took under advisement the motions filed by Blue Cross and Blue Shield of Michigan to reconsider this Court's orders of February 25, 1982, the Attorney General's responses, and the proposal by Blue Cross and Blue Shield of Michigan that, after the receipt of an executive message under GCR

1963, 797.1(a) by March 15, 1982, it would cancel the rate increase and credit or refund to subscribers payments made pursuant to the rate increase, and would not cancel subscribers for failure to pay the rate increase or further increase rates without prior approval by the Commissioner of Insurance.

The executive message of the governor pursuant to GCR 1963, 797.1(a) was received on March 15, 1982, requesting that this Court direct the Ingham circuit court to certify certain questions for immediate determination by this Court. The executive message of the governor is considered, and, pursuant to GCR 1963, 797.1(a), we direct the Ingham circuit court to certify the controlling question or questions of public law involved in the case of *Blue Cross and Blue Shield of Michigan* v. *Governor of the State of Michigan et al.* (Circuit Court No. 81-26748) to this Court with a statement of the facts relevant thereto sufficient to make clear the application of the question or questions. The Ingham circuit court shall file the certification of the questions and statement of facts with this Court by April 16, 1982. If the circuit court concludes that it cannot state the relevant facts without having conducted evidentiary hearings, the circuit court shall so inform this Court in writing by April 16, 1982, specifying which of the certified questions requires factual determinations made after an evidentiary hearing and the factual issues relevant to each such question. Such a notice by the circuit court shall include a proposed schedule for conducting such evidentiary hearings and an estimate of the length of time that would be required for hearings.

Pending this Court's consideration of the certified question or questions and any further proceedings in the circuit court under GCR 1963, 797.1(d), Blue Cross and Blue Shield of Michigan

(1) shall cancel and rescind the rate increase,

(2) shall credit to current subscribers and refund to former subscribers any amounts paid by the subscribers pursuant to the rate increase,

(3) shall not cancel or terminate any subscriber because the subscriber has failed to pay the rate increase,

(4) shall not cancel or terminate any subscriber for failure to pay a premium which includes the rate increase before giving the subscriber 10 days' written notice that the subscriber need only pay the amount of the premium applicable before the rate increase,

(5) shall not raise Blue Shield rates without the prior approval of the commissioner of insurance.

The schedule for briefing and argument will be established on receipt of the certified question or questions and statement of facts from the circuit court.

Pending consideration by this Court of the certified question or questions, further proceedings in the case of *Commissioner of Insurance* v. *Blue Cross and Blue Shield of Michigan* (Docket No. 68876) are stayed.

Ingham County Circuit Court Certification of Controlling Questions of Public Law and Statement of Need to Conduct Evidentiary Hearings, April 15, 1982

STATE OF MICHIGAN
IN THE SUPREME COURT OF MICHIGAN

SC: 68903, LC: 81-26748

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
a non-profit Michigan corporation,

Plaintiff,

—v.—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

CERTIFICATION OF CONTROLLING QUESTIONS OF PUBLIC LAW

STATEMENT OF NEED TO CONDUCT EVIDENTIARY HEARINGS

FACTUAL ISSUES RELEVANT TO CONTROLLING QUESTIONS

PROPOSED SCHEDULE OF EVIDENTIARY HEARINGS

Comes now Jack W. Warren, Circuit Judge of the Ingham County Circuit Court, and in compliance with the Order of this Court dated March 25, 1982, certifies that the following are deemed to be the controlling questions of public law involved in the above-entitled case:

1. Does there exist a contractual relationship between Blue Cross and Blue Shield of Michigan (BCBSM) and the State of Michigan and, if so, does 1980 PA 350 (the Act) unconstitutionally impair that contract?

2. Does the Act unconstitutionally impair any private contractual rights which exist between BCBSM and its subscribers and between BCBSM and its members?

3. Does the Act unconstitutionally delegate governmental authority and functions to BCBSM?

4. Does the Act include standards as reasonably precise as the subject matter of the legislation requires or permits so as to constitute a valid delegation of power to administrative and executive officials?

5. Does the Act unconstitutionally deprive BCBSM of equal protection of the law by regulating BCBSM in an arbitrary and discriminatory manner that bears no reasonable relation to the object of the legislation?

6. Does Section 301(7) of the Act unconstitutionally deprive BCBSM, its directors, officers, and/or corporate members of guaranteed rights of freedom of expression?

7. Does the Act convert BCBSM to a government agency? If so, does that unconstitutionally deprive BCBSM of liberty and property?

8. Prior to the effective date of the Act was BCBSM unlawfully entering into Administrative Services Only arrangements or marketing life insurance policies in conjunction with health care coverage?

9. Does the Act unconstitutionally deprive BCBSM of liberty and property without due process of law by:

(a) prohibiting BCBSM from engaging in certain lines of business?

(b) imposing unduly oppressive and burdensome restrictions on the operation of BCBSM's claimed legitimate business practices?

(c) providing administrative procedures lacking in due process guarantees and protections?

Need to Conduct Evidentiary Hearings

The undersigned is unable to state the facts relevant to the controlling questions of public law without conducting evidentiary hearings.

Factual Determinations Necessary

The following factual determinations are deemed necessary: *As to Controlling Question of Public Law #1* ("Does there exist a contractual relationship between Blue Cross and Blue Shield of Michigan (BCBSM) and the State of Michigan, and if so, does 1980 PA 350 (the Act) unconstitutionally impair that contract?"):

(a) When and on what basis were Blue Cross of Michigan and Blue Shield of Michigan formed as separate corporations?

(b) What was the nature of the relationship between Blue Cross of Michigan and Blue Shield of Michigan as originally formed?

(c) When and on what basis was Blue Cross and Blue Shield of Michigan (BCBSM) formed as a new legal entity?

(d) What was the relationship existing between BCBSM and the State of Michigan prior to 1980 PA 350 (the Act)?

(e) Where has the power to control the corporate structure of BCBSM been historically placed?

(f) Historically, who has had the power to elect the corporate members and directors of BCBSM?

(g) Historically, what has been the relationship between the Governor of the State of Michigan and BCBSM?

(h) Historically, what has been the relationship between the Attorney General of the State of Michigan and BCBSM?

(i) Historically, what has been the relationship between the Commissioner of Insurance of the State of Michigan and BCBSM?

(j) Does the Act impair vested contract or property rights acquired under a legitimate exercise of powers granted BCBSM in 1975?

(k) Is the Act a necessary or acceptable means of achieving some legitimate state interest?

(l) Is there any reasonable justification for the impairment of contract between the State of Michigan and BCBSM as formed in 1975?

(m) What is the date of BCBSM's contract with the State of Michigan?

(n) What impact does BCBSM have on the public health and general welfare of the people of the State of Michigan?

(o) What impact does BCBSM have on the Michigan economy?

As to Controlling Question of Public Law # 2 ("Does the Act unconstitutionally impair any private contractual rights which exist between BCBSM and its subscribers and between BCBSM and its members?"):

(a) Historically, who has had the power to control the by-laws and articles of incorporation of BCBSM?

(b) Historically, who has had the power to elect the corporate members and directors of BCBSM?

(c) What contracts between BCBSM and its customers are voided by the Act?

(d) What is the nature of the contracts between BCBSM and its customers that are voided by the Act?

(e) What is the nature of BCBSM ASO contracts?

(f) What is the need for ASO contracts in the State of Michigan?

(g) What is the nature of BCBSM's "packaging" contracts?

(h) What is the need for "packaging" contracts in the State of Michigan?

(i) What emergency or other justification exists in the State of Michigan that would justify the impairment of private vested contract rights?

(j) Which private contractual rights have been violated?

(k) Which private persons have vested property or contract rights?

(l) What is the relationship between the private vested contracts and the public health and general welfare of the people of the State of Michigan?

(m) What regulatory problems are confronted by allowing ASO contracts and "packaging"?

(n) What state interests exist in creating and maintaining and preserving a competitive market for health care and are such furthered by limitations on the scope of BCBSM's business?

(o) Has the State of Michigan ever formally disapproved or taken any other steps to block or prohibit ASO and packaging contracts?

As to Controlling Question of Public Law # 3 ("Does the Act unconstitutionally delegate governmental authority and functions to BCBSM?"):

(a) Historically, who has had the power and duty to formulate policy relative to the health care finance system in the State of Michigan?

(b) What role has the federal government played in formulating policy for the health care financing system in Michigan?

(c) What is the function of Health Systems Agencies in the State of Michigan with regard to formulating policy for the health care finance system?

(d) What will BCBSM be required to do to assure access to, quality of, and reasonable cost of health care to all persons in the State of Michigan?

(e) To what extent will BCBSM be required to make nondelegable, governmental policy decisions?

As to Controlling Question of Public Law # 4 ("Does the Act include standards as reasonably precise as the subject matter of the legislation requires or permits so as to constitute a valid delegation of power to administrative and executive officials?"):

(a) Historically, who has had the power to define BCBSM lines of business?

(b) What is the importance of defining BCBSM lines of business?

(c) Historically, who has had the power to develop risk factors for BCBSM lines of business?

(d) What is the importance of developing risk factors for BCBSM lines of business?

(e) Historically, who has had the power to control BCBSM reserve levels?

(f) What is the importance of controlling BCBSM reserve levels?

As to Controlling Question of Public Law # 5 ("Does the Act unconstitutionally deprive BCBSM of equal protection of the law by regulating BCBSM in an arbitrary and discriminatory manner that bears no reasonable relation to the object of the legislation?"):

(a) To what entities does PA 350 apply?

(b) How is BCBSM like and unlike other entities providing health care coverage to persons in the State of Michigan?

(c) How is BCBSM regulated differently and apart from other business entities providing health care coverage to persons in the State of Michigan?

(d) To what extent has the Commissioner of Insurance chosen not to regulate other business entities providing health care coverage to persons in the State of Michigan?

(e) To what extent do other business entities providing health care coverage to persons in the State of Michigan engage in the same business practices as BCBSM?

(f) What is the necessary impact on BCBSM of various provisions of the Act?

(g) What is the relationship of various provisions of the Act to the objectives of the Act?

(h) Can the Act possibly achieve its purported objectives?

(i) What impact does BCBSM have on the public health and general welfare of the people of the State of Michigan?

(j) What private contracts are vitiated by the Act?

(k) What is the relationship between these private contracts and the public health and general welfare of the people of the State of Michigan?

(l) What regulatory problems are confronted by allowing ASO contracts and packaging?

(m) What state interests exist in creating and maintaining and preserving a competitive market for health care and how are such furthered by limitations on the scope of BCBSM's business?

As to Controlling Question of Public Law #6 ("Does Section 301(7) of the Act unconstitutionally deprive BCBSM, its directors, officers and/or corporate members of guaranteed rights of freedom of expression?"):

(a) Historically, who has had the power to elect corporate members and directors of BCBSM?

(b) What is the governmental purpose to be served by Section 301(7) of the Act?

(c) To what extent does the Act limit a legitimate exercise of free speech rights?

(d) Is Section 301(7) a necessary means of achieving some compelling state interest?

As to Controlling Question of Public Law #7 ("Does the Act convert BCBSM to a government agency? If so, does that unconstitutionally deprive BCBSM of liberty and property?"):

(a) Is BCBSM currently a private corporation?

(b) What is the governmental purpose to be served by the Act?

(c) What can, and what will BCBSM be required to do to assure access to, quality of, and reasonable cost of health care to all persons in the State of Michigan?

(d) Historically, who has had the power to control the corporate structure of BCBSM?

(e) Historically, who has had the power to elect the corporate members and directors of BCBSM?

(f) Historically, what has been the relationship between the Governor of the State of Michigan and BCBSM?

(g) Historically, what has been the relationship between the Commissioner of Insurance of the State of Michigan and BCBSM?

(h) Historically, what has been the relationship between the Attorney General of the State of Michigan and BCBSM?

(i) To what extent are these relationships altered by the Act?

(j) To whom do the assets of BCBSM revert upon dissolution of BCBSM?

As to Controlling Question of Public Law # 8 ("Prior to the effective date of the Act was BCBSM unlawfully entering into Administrative Services Only arrangements of marketing life insurance policies in conjunction with health care coverage?"):

The facts determined under Controlling Question of Public Law # 2 will apply to this Question as well.

As to Controlling Question of Public Law # 9 ("Does the Act unconstitutionally deprive BCBSM of liberty and property without due process of law by: (a) prohibiting BCBSM from engaging in certain lines of business? (b) imposing unduly oppressive and burdensome restrictions on the operation of BCBSM's claimed legitimate business practices? (c) providing administrative procedures lacking in due process guarantees and protections?"):

9(a):

(a) What is the governmental purpose to be served by the Act?

(b) To what entities in the State of Michigan does the Act apply?

(c) Is the Act discriminatory as to BCBSM?

(d) What is the nature of BCBSM ASO contracts?

(e) What is the nature of BCBSM "formula three" group contracts?

(f) What is the nature of BCBSM "packaging" contracts?

(g) What legitimate business practices does BCBSM now engage in which are vitiated by the Act?

(h) What legitimate business practices does BCBSM now engage in which are severely restricted by the Act?

(i) What is the necessary impact on BCBSM of various provisions of the Act?

(j) What obstacles are imposed by the Act that make it impossible to achieve the Act's purported objectives?

(k) What is the impact of BCBSM on the public health and general welfare of the State of Michigan?

(l) Which private contract rights are vitiated by the Act?

(m) What is the relationship between these private contract rights and the public health and general welfare of the people of the State of Michigan?

(n) What regulatory problems are confronted by allowing ASO contracts and packaging?

(o) What state interests exist in creating and maintaining and preserving a competitive market for health care and how are such furthered by limitations on the scope of BCBSM's business?

(p) Has the State of Michigan ever formally disapproved or taken any other formal steps to block ASO and packaging contracts?

(q) What is the date of BCBSM's contract with the State of Michigan?

9(b):

(a) What is the governmental purpose to be served by the Act?

(b) To what entities in the State of Michigan does the Act apply?

(c) What matters pertaining to BCBSM are now subject to contested case hearings?

(d) What are the costs associated with contested case hearings?

(e) What can, and what will BCBSM be required to do to assure access to, quality of, and reasonable cost of health care to all persons in the State of Michigan?

(f) Historically, what has been the relationship between the Commissioner of Insurance of the State of Michigan and BCBSM?

(g) What are the current procedures for reporting claims to BCBSM's customers?

(h) What is the need for BCBSM customers to receive claims listing information?

(i) What is the necessary impact on BCBSM of various provisions of the Act?

(j) Is the Act discriminatory as to BCBSM?

(k) What obstacles are imposed by the Act that make it impossible to achieve the Act's purported objectives?

(l) Does the Act impose any "unduly oppressive and burdensome restrictions" on the operation of a legitimate business?

(m) What is the impact of BCBSM on the public health and general welfare of the people of the State of Michigan?

(n) What private contracts are vitiated by the Act?

(o) What is the relationship between these private contracts and the public health and general welfare of the people of the State of Michigan?

(p) What regulatory problems are confronted by allowing ASO contracts and packaging?

(q) What state interests exist in creating and maintaining and preserving a competitive market for health care and how are such furthered by limitations on the scope of BCBSM's business?

9(c):

(a) What is an "independent hearing officer"?

(b) What is the Michigan Association of Administrative Law Judges and what do administrative law judges do?

ESTIMATE OF TIME AND PROPOSED SCHEDULE OF HEARINGS

I estimate as follows:

(a) That Counsel will not be fully prepared to proceed to evidentiary hearing before Monday, July 26, 1982.[1]

(b) That twenty-five (25) days will be required for presentation of evidence.[2]

---

1 Counsel for Plaintiff has informed me that he plans extensive discovery in advance of hearing.

2 My estimate takes into account the likelihood of delay resulting from witnesses having planned vacations at this time of year. It also allows for illness, unforeseen events, and lawyer optimism in presenting estimates of time required.

(c) That twenty-four (24) days will thereafter be required for review of the record, presentation of proposed determinations of fact, argument, and determination by the Court of the facts.

(d) That a report to this Court may be made by Friday, October 1, 1982.[3]

I therefore propose the following schedule:

Monday, July 26, 1982	Commence taking proofs.
Friday, August 27, 1982	Terminate taking proofs and commence review of records, schedule and hear arguments, draft determinations of fact.
Friday, October 1, 1982 . .	File with Supreme Court the determinations of fact.

Dated: April 15, 1982.

/s/ JACK W. WARREN

Jack W. Warren, *Circuit Judge*

---

3 The proposed schedule is presented with the assumption that this Court will be appointing a visiting Judge to assume and carry out my duties with the Ingham County Circuit Court. It is also assumed that the services of a court reporter will be available during the period of July 26, 1982 through August 27, 1982, and for all hearings between August 27, 1982 and September 30, 1982.

Ingham County Circuit Court Findings of Relevant Facts, November 1, 1982

STATE OF MICHIGAN
IN THE SUPREME COURT OF MICHIGAN

SC: 68903, LC: 81-26748

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a non-profit Michigan corporation,

Plaintiff,

—v.—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, and COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

RELEVANT FACTS

PLEASE NOTE: Many facts hereinafter set forth are pertinent not only to the subject matter under which they are positioned but to other subjects as well. Thus, and for example, Findings 245, 246, 248, 249, 250, 251, 252, 255, 256, 259, 260, and 392 relate to Allegations and Criticism made known to Legislators prior to the enactment of 1980 PA 350.

A. What the Supreme Court has said about Blue Cross and Blue Shield of Michigan [150a]

B. What the Supreme Court has said about Michigan's health care enabling legislation [152a]

C. Allegations and criticism made known to Legislators to the enactment of 1980 PA 350 [153a]

D. Health care costs at and before the enactment of 1980 PA 350 and the impact of the automobile industry [156a]

E.	Historical background	[163a]
F.	BCBSM today—corporate structure	[174a]
G.	BCBSM today—provider reimbursement	[180a]
H.	Cost containment	[185a]
I.	BCBSM's place in the market and health care costs	[194a]
J.	ASO	[200a]
K.	Packaging	[205a]
L.	New providers—new benefits	
	(1) State institution reimbursement	[212a]
	(2) Freestanding facilities	[214a]
	(3) Substance abuse	[218a]
M.	Regulatory/administrative costs	[221a]
N.	Per case participation	[224a]
O.	Section 205 contingency reserves and lines of business	[226a]
P.	Part 5	[232a]
Q.	Miscellaneous	[238a]

Comes now Jack W. Warren, Circuit Judge of the Ingham County Circuit Court, and in compliance with the Order of this Court dated March 25, 1982, sets forth the relevant facts as follows:

A. What the Supreme Court has said about Blue Cross and Blue Shield of Michigan.

(1) In *Blue Cross* v. *Insurance Commissioner*, 403 Mich 399; 270 NW2d 845 [1978], the Court said (and evidence submitted to the undersigned indicates):

"BCBSM is a unique creation. It is a non-profit tax-exempt 'charitable and benevolent institution',[5] incorporated pursuant to special enabling legislation enacted by the Michigan Legislature in 1939,[6] for the purpose of providing a mechanism for broad health care protection to the people of the State of Michigan." (415-416)

"BCBSM acts as an intermediary between its members, commonly known as the subscribers, and the hospitals and physicians who provide health care services, commonly known as the providers." (416)

"Most subscribers belong to groups such as labor unions, fraternal organizations, or governmental or professional associations. These groups independently determine what health care services they wish to secure for their members and then enter into individual contracts with BCBSM. Generally, the contracts provide that the subscribers will each pay a periodic subscription fee to BCBSM and BCBSM in return will arrange for the provision of the desired services. The subscribers pay the subscription fee regardless of whether they actually utilize the services. Thus, the cost of the services to any individual subscriber who does utilize them is shared by the entire group to which the subscriber belongs. In many cases, the subscription fee is paid by the subscriber's employer. Often, such arrangements are the result of hard-fought collective bargaining agreements." (416)

"After the subscriber contracts have been negotiated, BCBSM enters into separate contracts with providers. The providers agree to furnish the desired services in return for a set fee to be paid by BCBSM. The providers who enter into such contracts are known as participating providers, while those who do not are known as non-participating providers." (416-417)

"BCBSM has a distinct contractual relationship both with its subscribers and with the participating providers. Other entities in the health care protection field, most notably

health insurance companies, do not enjoy such a position. They have a contractual relationship only with their policyholders. Unlike BCBSM, they do not have direct access to both sides of the health care equation.

5. MCL 550.315; MSA 24.605 and MCL 550.515; MSA 24.635.
6. 1939 PA 198, 109."

B. What the Supreme Court has said about Michigan's health care enabling legislation.

(2) In the same case the Michigan Supreme Court reviewed the history of Michigan's health care enabling legislation saying:

"By the 1920's it was becoming apparent that there was a serious nationwide problem in the distribution of medical care. Many people who needed it were not receiving it. The poverty of the Great Depression intensified this problem." (419)

"The high relative cost of medical care was one cause of this distressing situation. Another equally important cause was the irregular manner in which disease and injury strike and the wide variations in the services and the costs involved." (420)

"The business sector had not moved to rectify the problem of bringing together the people in need of health care and those who could provide it." (420)

"The Michigan enabling legislation sought to legitimatize the prepaid group health benefit plans. The ultimate purpose of the legislation was to enable the people in need of health care protection to become members of a group plan so that adequate hospital and medical care would be within the financial grasp of as many people as possible. As stated in the first section of the legislation, MCL 550.301; MSA 24.591, '[i]t is the purpose and intent of this act, and the policy of the legislature, to promote a wider distribution of medical care * *' ".

"In an effort to keep the rates charged to the subscribers of the plans as low as possible, the Legislature decreed that the plans must operate on a nonprofit basis.[23] To reduce the further plans' operating expenses, the Legislature decreed that the plans would be tax-exempt.[24] The Legislature even included sections in the enabling legislation which authorized the corporations administering the plans to accept charitable contributions to pay the subscription rates of persons who could not afford to pay the rates themselves.[25]

23. MCL 550.302; MSA 24.592 and MCL 550.501; MSA 24.621.
24. MCL 550.315; MSA 24.605 and MCL 550.515; MSA 24.635.
25. MCL 550.313; MSA 24.603 and MCL 550.510; MSA 24.630."

C. Allegations and criticism made known to Legislators prior to the enactment of 1980 PA 350

(3) Allegations and criticism made known to Legislators prior to the enactment of 1980 PA 350 included the following:

(a) BCBSM is a dominant force in the health care economics of the State. It provides coverage for medical and hospital care to nearly five and one-half million persons, more than 60 percent of the State's population; it has contracts with all but one of the hospitals in the State and with 71 percent of the physicians; and it administers the Federal Medicare program. The actions of BCBSM have a significant impact on the lives of the people in the State and on the operations of the State's business. (Def Ex. 96 p 1) The rates the BCBSM pays and its methods for determining payments set the standard for the 60 percent of the market it has *and* for the rest of the market covered by Medicare, Medicaid, profit-making insurance companies, and others who have no insurance at all. (Def Ex. 93 p 1)

(b) Health care costs are adversely affecting Ford Motor Company. While the health care benefit package for Ford

hourly workers is the same no matter where they live, in 1978, the cost to Ford for BCBSM coverage in Southeastern Michigan was greater per employee than any place Ford operates in the country. Ford pay-out in Southeastern Michigan per employee was more than double that in the Metuchen/Mahwah, New Jersey and Albany/Buffalo, New York areas. It was slightly less than double the pay-out in Louisville, Kentucky and Minneapolis/St. Paul, Minnesota areas. (Def Ex. 93 p 1 and Table 1)

(c) Health care costs are adversely affecting General Motors Corporation. During the year October 1, 1977 to September 30, 1978, compared to 21 areas in 12 other states, General Motors paid-out to BCBSM more money per hourly employee for surgical-medical costs in Michigan than in any of the selected areas other than Southern California. (Def Ex. 93 Table 3)

(d) Health care costs are adversely affecting Chrysler Corporation. In 1977, it paid (per UAW-represented employee) $1,059 for hospital-surgical-medical (BCBSM) coverage. In 1978, the cost was $1,321 for an increase of 25 percent. In Delaware and Illinois, the increase was only 6 percent. In Indiana, it was 13 percent. (Def Ex. 93 Table 4)

(e) In recent years, BCBSM has been the subject of considerable controversy. Its critics charge it with being unduly secretive, unresponsive to consumer interests, and not vigorous enough in its cost containment efforts. (Def Ex. 96 p 1)

(f) Rates paid for Blues coverage in Michigan are higher—in some cases by far—than rates for comparable coverage in other states. Concern about the rates is especially strong among the State's senior citizens, for whom rates tend to be both particularly high and particularly burdensome. (Def Ex. 96 p 1)

(g) Some persons have been upset at (occasionally furtive) increases in the administrative expenses of BCBSM. (Def Ex. 96 p 1)

(h) The board of directors of BCBSM has been dominated by providers. (This at the expense of the consumer.) (Def Ex. 96 p 1)

(i) The board of directors of BCBSM has been subject to excessive management influence. (Def Ex. 96 p 1)

(j) The State's authority to regulate BCBSM is not clearly defined under present law. (Def Ex. 96 p 1)

(k) Since BCBSM's powerful position in the health care marketplace has been achieved in no small part due to advantages it has been granted in statute by the Legislature, the public has a right—and its representatives have a responsibility—to see that the Corporation's influence is used in the public interest. (Def Ex. 96 p 1-2)

(l) There has been recent concern over the continual rise in health care costs above increases in the general cost of living. (Def Ex. 96 p 2)

(m) BCBSM is, by legislative declaration, a tax-exempt, charitable, and benevolent organization, a status which gives it considerable advantages in the marketplace. (Its largest competitor has less than a 5 percent market share.) (Def Ex. 96 p 6)

(n) There is an insufficient number of public members on the BCBSM board of directors. Public representation is necessary in order to monitor the cost control efforts of BCBSM. (Def Ex. 96 p 6)

(o) Roll call votes are necessary in BCBSM board of directors meetings to help ensure the accountability of the directors to their constituencies. (Def Ex. 96 p 9)

(p) Since BCBSM has no shareholders, its accountability ought to be predominantly to its subscribers. (Def Ex. 77 p 3)

(q) BCBSM is proposing rate increases in Medicare supplemental insurance which it sells to the elderly. The proposed rates constitute a 57 percent increase. For this additional 57 percent, the elderly will be required to wait six months before coverage begins in place of a no-waiting period. (Def Ex. 83 p 3)

(r) BCBSM maintains excessive reserves to the detriment of subscribers. (Def Ex. 83 p 5)

(s) BCBSM is engaging in the sale of life insurance without the specific approval of the Insurance Commissioner. (Def Ex. 79 p 5)

(t) BCBSM is marketing Administrative Services Only contracts without the specific approval of the Insurance Commissioner. (Def Ex. 79 p 5)

(u) There exists a need for substance abuse services. *Allowing* the selection of coverage for substance abuse services rather than *requiring* such coverage does not work well. (Brown 3672-3673) In many instances the individual alcoholic or drug addict would not pay, or could not pay for outpatient substance abuse services, and because of a lack of services, the alcoholic would continue to drink and would eventually end up needing more expensive hospital care. (Pierce 3528-3529)

(v) There exists a need for mandatory prosthetic devices coverage. (Brown 3680-3682)

D. Health care costs at and before the enactment of 1980 PA 350 and the impact on the automobile industry.

(4) Under Public Act 323 of 1978, the State is obligated to spell out, on a regular basis, the State's policies with respect to the health-care system. The State Health Plan is the document by which those policies are expressed. (Rosen 2435)

(5) The State Health Plan articulates long-range policy with respect to the number and type of health facilities needed in Michigan; it articulates long-term policy with respect to the type of health personnel that we ought to have; and it articulates a long-range policy with respect to the amount of money that we can afford to spend for health in Michigan. (Rosen 2542-2543)

(6) The Statewide Health Coordinating Council is a 54-member body. It is appointed by the Governor with the consent of the Senate. Its composition consists of 60 percent consumers and 40 percent providers. Every part of the State is represented. (Rosen 2653-2654) Two members of the Senate and two members of the House serve on the council. (Rosen 2469)

(7) Once approved by the Statewide Health Coordinating Council, the State Health Plan, under Michigan law, must be approved by the Governor and Legislature. (Rosen 2536) The

statute (1978 PA 323) specifically requires that the Plan be reviewed by the health committee of each House. Extensive joint and separate hearings are held on the plan, and ultimately, both Houses vote on the plan. (Rosen 2537-2538)

(8) Defendants' Exhibit 33 ("State Health Plan for Michigan 1979-1983") was adopted before the enactment of 1980 PA 350. (Rosen 2435)

(9) Defendants' Exhibit 35 is the second State Health Plan for 1980-1984. It was developed during 1980 and approved by the Governor and Legislature in the fall of 1981. (Rosen 2435) While it was being developed, drafts were submitted to the Legislature. (Rosen 2469)

(10) The rapid escalation of health care expenditures is widely recognized as a major problem. Nationally and within Michigan, not only the absolute amount but the proportion of total resources devoted to producing health services has increased rapidly. In fiscal year 1960 health care expenditures were 5.2 percent of gross national product; in fiscal year 1977 they were 8.8 percent of gross national product. This represents a 69 percent increase in the proportion of total product at a time when the size of that total product was expanding significantly. Expenditures in Michigan almost certainly paralleled the national trends during the period. (Def Ex. 33 State Health Plan for Michigan, 1979-1983, p 481)

(11) Past trends and analysis of the characteristics of the economics of the medical system suggest that unless steps are taken to curtail the rise in expenditures, the medical system will continue to absorb an ever-increasing proportion of the State's income and resources. Since the marginal improvements in health that are associated with each additional dollar of expenditures tend to grow smaller as more is spent, at some point it is appropriate to stop spending additional money for health care services since those dollars have to be taken away from other priority uses. (Def Ex. 33 State Health Plan for Michigan, 1979-1983, p 481)

(12) In calendar year 1960, health care expenditures were 5.3 percent of gross national product; in 1978, they were 9.1 percent of gross national product. This represents a 72 percent increase in the proportion of total product at a time when the size of the total product was expanding significantly. Expenditures in Michigan almost certainly parelleled the national trends during the period. (Def Ex. 35 State Health Plan for Michigan, 1980-1984, p 609)

(13) Physician services account for 18.3 percent of national health expenditures. (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 679)

(14) Hospitals account for 39.5 percent of the total national health care expenditures. (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 631)

(15) In 1975, Michigan had a per capita hospital expense of $207.14. In 1980 it was $382.87 for an increase of 84.8 percent. (Michigan ranked sixth highest amongst the various states and the District of Columbia in both years.) (Pls Ex. 28, Table XIII)

(16) The cost per adjusted admission in Michigan in 1977 was $1,486.10. In 1980 it was $2,086.52 for an increase of 40.4 percent. The national average was $1,850.96 in 1980. (Pls Ex. 28, Table XIV)

(17) The expense per adjusted hospital inpatient day in Michigan increased 41.4 percent between 1977 and 1980. (Pls Ex. 28, Table XI)

(18) The total of hospital expenses in Michigan in 1975 was $1,880,434,000 (sixth highest amongst the various states and the District of Columbia). In 1980, it was $3,539,256,000 (seventh highest). The increase was 88.2 percent. (Pls Ex. 28, Table X)

(19) The precise percentage of per capita income spent in Michigan for health care services has not been established. In 1978 the figure was 10.6 percent while the national average was

10.7 percent. (This is based on the assumption that per capita health expenditures in Michigan are 5 percent above the national average, as they were in 1969, the last year for which data is available.) (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 609)

(20) In recent years the rate of increase of *hospital* expenditures has been rising nationally at a rate almost 40 percent faster than the rate at which gross national product has been growing. From 1968 to 1978, total GNP grew at an average rate of 9.2 percent. During the same period, *hospital* expenditures grew at the rate of 12.7 percent on an annual basis. (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 631)

(21) Nationally, for *physicians*, the proportion of GNP spent on their services increased by 31 percent in the decade from 1968 to 1978, increasing from 1.3 percent of GNP to 1.7 percent. Michigan experience parallels the national experience. (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 679)

(22) Between 1968 and 1978, assuming Michigan experience to be like national experience, expenditures for physicians services were rising at a rate of 30 percent higher than the rate at which Michigan citizens' incomes were rising. (Def Ex. 35 State Health Plan for Michigan 1980-1984, p 679)

(23) *As to Ford Motor Company*:

(a) Over fifty percent of all Ford Motor Company employees work in Michigan and are provided with BCBSM prepaid health care coverage. (Shelton 2559 and 2608-2609)

(b) There are approximately three dependants who are covered with each employee. (Shelton 2619 and 2814-2815)

(c) Upwards of ninety-nine percent of all Ford hourly employees come by these health care benefits by way of collective bargaining agreements. (Shelton 2595, 2784)

(d) Most Michigan Ford employees reside in Southeastern Michigan. (Shelton 2607)

(e) The areas where health care costs are highest are in Southeastern Michigan and Genesee County. (Pierce 3517)

(f) While John Hancock rather than Blue Cross and Blue Shield provides coverage in Georgia, Illinois, St. Louis, Missouri, Tennessee and Cleveland, Ohio, in all other locations in the United States, Blue Cross and Blue Shield Plans supply coverage. Of importance, however, is the fact that the benefits are the same in all states. (Shelton 2595, 2606, 2834)

(g) Nationwide, health care costs for Ford hourly employees amounts to 12 percent of each employee's compensation. This means over $2.50 an hour for each employee in 1981. (Shelton 2899)

(h) The health care cost for Michigan employees of Ford is higher than in any other state. (Shelton 2617, 2900)

(i) Because over 50 percent of Ford's health care costs are incurred in Michigan, state health care cost trends impact significantly upon total company cost. If hospital and physician payment per contract for Michigan in 1978 could have been contained to just the *average* experienced in all other states, company costs would have been reduced over $50 million—a savings of over 14 percent over the total hospital and physician cost of all U.S. employees, on an average of $12 per vehicle. In 1980, the reduction would have been $64 million—a savings of over 15 percent, or $34 per vehicle. (Def Ex. 53)

(j) The cost for coverage of Blue Cross and Blue Shield salaried employees in Michigan is also the highest in the nation. (Shelton 2899)

(k) The Blue Cross and Blue Shield cost per hourly employee in the Metuchen and Mahwah plants of New Jersey was 47 percent of the Michigan cost. (Shelton 2611 and Def Ex. 95, Table 1 and Def Ex. 50) The Albany and Buffalo, New York plans were 48 percent of Michigan costs. Both Louisville, Kentucky and the Minneapolis/St. Paul, Minnesota plans were 58 percent of Michigan costs. (Def Ex. 95, Table 1 and Ex. 50) (Note: In New Jersey, hospital rates are set by a State Hospital Rate Commission.) (Manzo 1730, 1767-1768) New York likewise sets hospital rates. (Shelton 2836-2837)

(24) *As to General Motors Corporation*:

(a) General Motors, in contrast to Ford, has a much more disbursed work force in the State of Michigan, with probably half of it being in Southeast Michigan and the other half disbursed throughout the State. It is not surprising, therefore, that General Motors cost figures are, relatively speaking, better than Ford's and Chrysler's whose employees are largely in the more costly, Southeastern part of the State. (Pierce 3517-3518, 3562)

(b) Average *surgical-medical* (Blue Shield) cost per contract per month for hourly employees of General Motors for the year October 1, 1977 to September 30, 1978, were higher in Michigan than in any other location except Southern California. It was at least double that of Rochester, New York (48%) and New Jersey (50%). It was almost double that of New York, New York (53%), Massachusetts (53%), and Pittsburgh, Pennsylvania (56%). Compared to General Motors' Michigan Blue Shield costs, others ranked as follows:

New York (Buffalo)	67%
Maryland	69%
Indiana	72%
Cleveland, Ohio	74%
Milwaukee, Wisconsin	75%
Delaware	78%
Northern California	85%
Wisconsin, excluding Milwaukee	91%
Atlanta, Georgia	93%
Illinois	93%
St. Louis, Missouri	93%
Cincinnati, Ohio	93%
Columbus, Ohio	93%
Toledo, Ohio	93%
Kansas City, Missouri	95%
Michigan	100%
Southern California	107%

(Def Ex. 95, Table 3)

such hospitals may lawfully delegate to an agent."

(Pls Ex. 1 and Ex. 2, Murphy 1473)

(30) The original Plan of Operation of MSGH described the corporation as follows:

> "The Michigan Society for Group Hospitalization is an agency of a number of non-profit hospitals in Michigan; at the present time there are sixty-two participating. The Society was formed by the hospitals themselves to act as their agent in presenting a hospital service contract to the people of Michigan."
>
> (Pls Ex. 6)

(31) Members of the corporate body at the initial formation of MSGH were, for the most part, hospital representatives. (Murphy 1474)

(32) The Bylaws of MSGH provided that the affairs of the corporation were to be managed by a board of trustees of 25 persons: 13 representatives of hospitals; 6 representatives of the medical profession; and 6 representatives of the public. (Pls Ex. 2)

(33) The board of trustees of MSGH were nominated as follows: the hospital trustees by the participating hospitals; the medical trustees by the Michigan State Medical Society; and the public members by a nominating committee created by the board of trustees. (Pls Ex. 2)

(34) MSGH opened for business in February or March of 1939. (Murphy 1523)

(35) The original benefits offered by MSGH included: 21 days of hospital services in a given year, which would include room and board; general nursing service, operating room service; anesthesia; routine laboratory services; and ordinary drugs and dressings. (Pls Ex. 6, Murphy 1474, 1480)

(36) Originally, MSGH certificates were made available only to employee groups of 10 or more individuals. (Pls Ex. 6)

(37) On May 17, 1939, Acts 108 and 109 of 1939 were signed into law. (Murphy 1528)

(38) In December of 1939, MSGH came under Act 109 of 1939. (Murphy 1478)

(39) In July of 1940, MSGH changed its name to Michigan Hospital Service (MHS). (Pls Ex. 3)

On July 12, 1939, Michigan Medical Service (MMS), one of the predecessor corporations to BCBSM, was incorporated under Act 108 of 1939 in the State of Michigan. (Pls Ex. 4, Murphy 1475)

(40) MMS was formed by doctors, the original operating capital coming from the Michigan State Medical Society. (Murphy 1476, 1524)

(41) The Articles of Incorporation of MMS set forth the purposes of the corporation as follows:

> "To establish, maintain and operate a voluntary non-profit medical care plan, whereby medical care is provided at the expense of this corporation to such persons or groups of persons as shall become subscribers to such plan, such medical care to be furnished under written contracts, providing definite medical and surgical care, appliances and supplies by licensed and registered doctors of medicine in the offices of such doctors, or in hospitals, or in the homes of such subscribers."
>
> "To supply to the subscribers to any such plan such other similar or related benefits, not including hospital service, as the board of directors of this corporation shall designate and as shall have the prior approval of the Commissioner of Insurance of this state as to the character thereof and as to the financial ability of this corporation to carry out its agreements with respect thereto."
>
> "To accept charitable or benevolent trust gifts or legacies or devises intended for the benefit of public health or improvement of the health of the people of this state."

(c) Senator Pierce received from General Motors information which he did not distribute to his colleagues. This information indicated that as to average ***hospital*** (Blue Cross) cost per contract per month for hourly employees (October 1, 1977-September 30, 1978) General Motors' costs in Michigan were eighth highest of 22 locations. (Def Ex. 100, Table 1)

That as to average hospital, surgical-medical, drug (*Blue Cross and Blue Shield*) costs per contract per month for hourly employees during the same period, Michigan costs ranked sixth highest of 22 locations. Thus:

New Jersey	60%
New York, New York	62%
Buffalo, New York	63%
Rochester, New York	71%
Pittsburgh, Pennsylvania	81%
Massachusetts	82%
Maryland	82%
Milwaukee, Wisconsin	83%
Delaware	83%
Indiana	83%
Wisconsin, excluding Milwaukee	89%
Illinois	90%
Northern California	91%
Columbus, Ohio	92%
Cincinnati, Ohio	95%
Cleveland, Ohio	99%
Michigan	100%
Atlanta, Georgia	103%
Toledo, Ohio	106%
Kansas City, Missouri	110%
Southern California	110%
St. Louis, Missouri	120%

(Def Ex. 100, Table 7)

(25) *As to Chrysler Corporation*:

(a) Senator Pierce requested information from Chrysler which he distributed to his colleagues in the Legislature. This information dealt with hospital-surgical-medical claims (Blue Cross and Blue Shield) paid per active UAW-represented employee during years 1977 and 1978. This information distrubuted by Pierce indicated: That an average of $1,059 was paid in such claims per hourly employee in 1977; that an average of $1,321 was paid in such claims in 1978 constituting a 25 percent increase; and that during the same two-year period, Delaware hourly employees costs increased only 6 percent, Illinois hourly employees costs increased 6 percent, and Indiana employees of Chrysler costs increased 13 percent. (Def Ex. 96, Table 4)

(b) Admittedly, Senator Pierce requested data for only three of the states where Chrysler does business. He removed and did not distribute data received from Chrysler indicating varying direct labor costs for hospitals in those areas which differed by as much as $71 per day. (Pierce 3592 and Pls Ex. 48)

E. Historical background

(26) On October 3, 1938, the Michigan Society for Group Hospitalization (MSGH), one of the predecessor corporations to Blue Cross and Blue Shield of Michigan (BCBSM), was incorporated under the general non-profit corporation act in the State of Michigan. (Pls Ex. 1, Murphy 1473)

(27) MSGH was formed by community hospitals in the State of Michigan (Murphy 1473-1474)

(28) The original working capital for MSGH was provided as follows: Grace Hospital—$3,333.34; Harper Hospital—$3,333.33; Henry Ford Hospital—$3,333.33. (Pls Ex. 6, Murphy 1520-1521)

(29) The purpose of MSGH, as set forth in its Articles of Incorporation and Bylaws, was:

> "To act as agent for hospitals organized on a charitable or non-profit basis in the performance of any acts which

"To cooperate with any other corporation organized under the provisions of this or any similar act in establishing and operating non-profit medical care plans and to contract with such, or other corporations, or agencies, or other associations or persons with reference to the furnishing of medical care in connection with such plans, provided that all such contracts and/or plans of cooperation shall be approved by the said Commissioner of Insurance."

"To collect in connection with the operation of the plan statistics and data and to compile reports which may be deemed of value to the community, to the medical profession, and to the furtherance of the plan; to be of assistance in the promotion of such benevolent, scientific, educational, relief and other activities as are considered to be for the best interests of the community in relation to the health and welfare of the people, and to carry out all other purposes and objects of this corporation."

(Pls Ex. 4)

(42) The incorporators of MMS were its first members, and they elected the first board of directors. Election as a director made that person a member of the corporation. From and after the regular meeting of the House of Delegates of the Michigan State Medical Society in September of 1939, all members of said House of Delegates became members of the corporation and remained members so long as they remained members of the House of Delegates. The board of directors had authority to elect to membership in the corporation other persons not professionally practicing any healing art, however, such persons were never to constitute more than 10 percent of the total membership of the corporation. (Pls Ex. 4)

(43) The Articles of Incorporation of MMS provided for a board of directors of not less than 11 and no more than 35, at least two-thirds of which were to be doctors of medicine. (Pls Ex. 4)

(44) All of the incorporators and all of the original directors, save one, of MMS were medical doctors. (Pls Ex. 4)

(45) The original certificate offered by MMS provided for 30 days of medical care while in the hospital. (Murphy 1476, 1480)

(46) Part of the impetus in forming MMS came from MSGH because the first large group enrolled, Ford Motor Company, contracted with in 1940, strongly desired medical coverage to complement the hospitalization coverage. (Murphy 1523-1524)

(47) General Motors Corporation and Chrysler Corporation were added as subscribers of both corporations in 1941. (Murphy 1524)

(48) MSGH and MMS opened for business as separate corporations with separate Articles of Incorporation, separate Bylaws, and separate boards of directors. (Murphy 1476-1477, 1479)

(49) MSGH and MMS were housed in the same facility and shared much of the same staff for their day-to-day operations. (Murphy 1476-1477)

(50) MSGH and MMS offered separate certificates for the respective hospital and medical care coverages. (Murphy 1529)

(51) At the time MSGH and MMS opened for business, no commercial insurance companies were interested in writing health care insurance. (Murphy 1478-1479; Powsner 3116-3117)

(52) Hospital and medical prepayment plans such as MSGH and MMS were formed at a time when community hospitals were dying for lack of funds. (Powsner 3109-3110)

(53) At the time of the formation of MSGH and MMS, adequate hospital and medical care was not within the grasp of many people because of lack of funds. (The witness Asmussen indicated that payment "in chickens and eggs" in 1939 would not keep the doors of hospitals open.) (Asmussen 1361)

(54) The primary purpose of the individuals and hospitals involved in the founding of MSGH and MMS was to provide and carry out plans by which prepaid hospital and medical services would become available to many people who could not afford hospital and medical attention, and so that, in turn, financial resources could be made available to hospitals and doctors. (Powsner, 3146; Asmussen 1361; Def Ex. 64 p 1 of Proposed Reorganization Plan for Michigan Medical Service; see also *Blue Cross* v. *Insurance Commissioner*, 403 Mich 399, 422-423 where, in relation to the legislation under which they existed, it was stated:

> "The ultimate purpose of the legislation was to enable the people in need of health care protection to become members of a group plan so that adequate hospital and medical care would be within the financial grasp of as many people as possible."

(55) As to governmental control or intervention in relation to Bylaws and selection and composition of boards of directors under 1939 PA 108 and 109, MSGH and MMS:

(a) A copy of the *by-laws* of both corporations had to be filed with the office of Commissioner of Insurance. The Commissioner was required to examine such bylaws, and he or she had the power to conduct any investigation which he or she deemed necessary.

(PA 108 § 5; MCL 550.305; MSA 24.595)
(PA 109 § 6; MCL 550.506; MSA 24.626)

(b) The board of directors of a medical care corporation was required to have "representation from the public and the medical profession of the state . . ."

(PA 108 § 8; MCL 550.308; MSA 24.598)

(c) The hospital service corporation board of directors was required to have not less than 9 persons, with representation of participating hospitals, registered physicians, and the public; and each trustee or direc-

tor had to be elected for one year unless a longer term was prescribed in the articles or bylaws.

(PA 109 § 2; MCL 550.502; MSA 622)

(d) The provisions of Section 117 to 132 of 1931 PA 327 apply to both medical and hospital service corporation. (1939 PA 108 § 2; 1939 PA 109 § 1; MCL 550.302, MCL 550.501; MSA 24.592, 24.621)

Section 124 of 1931 PA 327 reads in part as follows:

"No such board shall be less than 3 in number, and each such trustee or director. . . shall be elected for 1 year unless a longer term is prescribed in the articles or the bylaws. The bylaws may prescribe that the directors shall be divided into three equal classes. In such case, the full number of said boards shall be elected at the first meeting of such corporation; the first class shall hold their office for one year; the second class for two years and the third class for three years; and at each annual meeting thereafter one-third of the total number of directors shall be elected who shall hold their office for 3 years and until their successor shall be elected . . . A majority of the directors shall be a quorum for the transaction of business . . . ."

(56) In 1941, then Attorney General Herbert J. Rushton issued a formal opinion that subscribers to MHS and MMS were not voting members of either corporation. (Pls Ex. 31)

(57) In 1946, a crisis arose when several hospitals in Detroit departicipated for lack of adequate reimbursement and the Insurance Commissioner suspended MHS's authority to issue any new certificates. MHS then switched to cost reimbursement for hospitals which allowed MHS to regain the participation of hospitals and to resume doing business. (Powsner 3112, 3118-3119; Bush 896)

(58) MHS instituted cost containment programs for hospitals as early as 1946-1947. (Powsner 3113)

(59) In the 1950's, consumer representatives were added to the MMS board of directors. (Murphy 1530-1531)

(60) In 1963, MMS amended its Articles of Incorporation to provide for 40 percent "public members." (Def Ex. 63)

(61) In 1971, MMS officially changed its name to Blue Shield of Michigan. (Murphy 1484)

(62) In August of 1970, John McCabe, President of Blue Shield, reported to the then Commissioner of Insurance that a special meeting of the Board of Directors was held on August 19, 1970 to consider revising Michigan Blue Shield's Board and Corporate structure "so as to extend consumer and public involvement." He reported further that the Board voted on that date to accept the recommendation of the Executive Committee "as detailed in the accompanying exhibits." One of the accompanying exhibits entitled "Revised Proposed Amendments to the Articles of Incorporation" contained a provision that within not more than four (4) months after the date upon which the Amended Articles of Incorporation shall become effective, corporate members shall include six (6) persons named by the Commissioner of Insurance. Another accompanying exhibit entitled "Composition of First Board of Directors Under Proposed Structure" demonstrated an intent that two (2) of the six (6) persons named by the Insurance Commissioner would serve on the Board of Directors. (Def Ex. 64)

(63) The actual accomplishment of amending the Articles of Incorporation to provide for the Commissioner of Insurance appointees serving as corporate members and members of the Board of Directors did not occur until 1973. (The certificate of the Commissioner of Insurance approving the amendments is dated November 5, 1973.) (Def Ex. 65)

(64) By the 1960's, MHS was widely identified with the Blue Cross symbol, though no formal name change was made. (Murphy 1482)

(65) In 1961, MHS voluntarily adopted a new statement of corporate purposes which, in addition to acting as agent for

hospitals, committed MHS to providing prepaid hospital care to the people of Michigan. (Murphy 1508)

(66) In 1964, the MHS board of directors became a consumer majority body. (Murphy 1509)

(67) In 1974, the Insurance Commissioner wrote MHS and Blue Shield relative to exploring the possibility of the two corporations merging. (Murphy 1485)

(68) On December 5, 1974, the board of directors of MHS voted to consolidate with Blue Shield of Michigan. On December 18, 1974, the board of directors of Blue Shield of Michigan voted to consolidate with MHS. (Pls Ex. 9)

(69) On December 31, 1974, MHS and Blue Shield of Michigan filed a Plan of Consolidation with the Insurance Commissioner, to create a new corporation, BCBSM. (Pls Ex. 8)

(70) Acts 331 and 332 of 1974, amending acts 108 and 109 of 1939, were passed to facilitate the consolidation of MHS and Blue Shield of Michigan. (Murphy 1486)

(71) The two corporations desired consolidation so as to make the operations thereof as efficient as possible. (Murphy 1488)

(72) Pursuant to the Plan of Consolidation, the *corporate membership* was to be comprised of the boards of directors of MHS and Blue Shield of Michigan, and would be constituted as follows:

a. 14 doctors of medicine
b. 4 doctors of osteopathy
c. 18 representatives of hospitals
d. 2 pharmacists
e. 28 representatives of consumers-groups
f. 10 representatives of consumers-labor
g. 12 representatives of consumers-at-large
h. 4 consumer representatives nominated by the Insurance Commissioner

i. The chairman of the board and the president of the corporation.

(Murphy 1487; Pls Ex. 8)

(73) The Plan of Consolidation provided for a *board of directors* elected from the corporate membership as follows:

a. 7 doctors of medicine
b. 2 doctors of osteopathy
c. 9 hospital representatives
d. 1 pharmacist
e. 14 representatives of consumers-groups
f. 5 representatives of consumers-labor
g. 6 representatives of consumers-at-large
h. 2 consumer representatives nominated by the Insurance Commissioner
i. The chairman of the board and the president of the corporation.

(Pls Ex. 8)

(74) The Plan of Consolidation was approved by the Insurance Commissioner on January 23, 1975. (Pls Ex. 10)

(75) The voluntary allowance for Insurance Commissioner nominees on the corporate body and board of directors was carried over from Blue Shield. (Murphy 1499)

(76) The proposed Restated Articles of Incorporation stated as the purposes of BCBSM:

a. To carry out the objects of the Plan of Consolidation filed in accordance with Acts Nos. 331 and 332, Public Acts of 1974.
b. To exercise all of the powers of a medical care corporation organized under Act 108 of 1939 as now or hereafter amended, and of a hospital service corporation organized under the provisions of Act 109 of 1939 as now or hereafter amended.
c. To have and exercise all the rights, powers, privileges, immunities and franchises of the consolidating

corporations under Act 108, as amended, and Act 109 as amended, and in general, to do all acts and things, and to carry on all businesses in connection and incident thereto not violative of the laws of the State of Michigan.

(Pls Ex. 11)

(77) The proposed Restated Articles of Incorporation provided for a corporate membership and board of directors as set forth in the Plan of Consolidation. (Pls Ex. 11)

(78) The Restated Articles of Incorporation vested the power to adopt, alter, or amend the *Bylaws* of BCBSM in the board of directors. (Pls Ex. 11 ARTICLE VII)

(79) The Restated Articles of Incorporation vested authority to amend the Articles of Incorporation in the Corporate membership, this "in the manner provided by Section 4 of Act 108, Public Act of Michigan of 1939, as amended, and Section 5 of Act 109, Public Acts of Michigan of 1939, as amended, . . ." (Pls Ex. 11 ARTICLE VIII)

(80) The Attorney General approved the Restated Articles of Incorporation on February 13, 1976. (Pls Ex. 11)

(81) The Insurance Commissioner approved the Restated Articles of Incorporation on February 18, 1976. (Pls Ex. 14)

(82) The Insurance Commissioner issued a Certificate of Authority to BCBSM on April 15, 1976, made effective January 1, 1975. (Pls Ex. 13; Murphy 1484)

(83) The original Bylaws of the consolidated corporation called for a corporate membership and board of directors constituted as stated in the Plan of Consolidation. (Pls Ex. 8, 12)

(84) After providing for various initial terms less than three years duration (in an effort to reach an objective of voting on a near equal number of directors each year), the Bylaws of the consolidated corporation called for terms of the board of directors to be three years. (Pls Ex. 12)

(85) The Bylaws of the consolidated corporation vested authority to alter, amend, or repeal Articles I, II, IV, and IX of the Bylaws in the corporate membership. (Pls Ex. 12)

F. BCBSM today—corporate structure

(86) BCBSM is managed by a board of directors, 59% of which represent consumers of health care services. (Pls Ex. 15; Murphy 1493-1494)

(87) The *corporate membership* of BCBSM is comprised of 93 persons as follows:

a. Consumers-groups: 28 representatives of substantial group purchasers of BCBSM coverage.

b. Consumers-labor: 10 representatives of unions which have substantial membership in BCBSM.

c. Consumers-at-large: 12 consumers who shall be subscribers to BCBSM, influential in the community and not representative of another component.

d. Consumers-appointed: 4 consumers named by the Insurance Commissioner who do not hold elective office, are not government employees and are not affiliated with the insurance industry.

e. Doctors of medicine: 14

f. Doctors of osteopathy: 4

g. Hospital representatives: 18

h. Pharmacists: 2

i. President of BCBSM

(Pls Ex. 15)

(88) All terms of corporate membership are for a period of three years. (Pls Ex. 15)

(89) Thirty-five (35) members constitute a quorum at any Annual or Special Meeting of the members. (Pls Ex. 15)

(90) Nominations to the corporate membership come from the respective component groups, acting as a whole through a nominating committee, and where appropriate, after consulta-

tion with respective external designating entities, and then the nominees are elected by the corporate membership as a whole.

(91) Any subscriber who meets the qualifications of the Bylaws is eligible to be nominated to the consumers-at-large component of the corporate membership. (Murphy 1503)

(92) Examples of external designating entities would be the UAW, AFL-CIO, the five largest groups, the Insurance Commissioner, Michigan State Medical Society, and the Michigan Association of Osteopathic Physicians. (Murphy 1496-1497, 1500-1501)

(93) For nomination of hospital representatives, the state is divided into six regions from which the participating hospitals in each region make their nominations. (Murphy 1501)

(94) Following nomination by the respective components, the entire corporate membership then votes on those nominees. (Murphy 1552-1553)

(95) The *board of directors* of BCBSM is comprised of 47 persons as follows:

a. 14 representatives of consumers-groups
b. 5 representatives of consumers-labor
c. 6 representatives of consumers-at-large
d. 2 nominated by the Insurance Commissioner
e. 7 doctors of medicine
f. 2 doctors of osteopathy
g. 9 hospital representatives
h. 1 pharmacist
i. The President of BCBSM.

(Pls Ex. 15)

(96) The board of directors is selected from the corporate membership by the corporate membership. (Murphy 1487)

(97) At the present time, all terms on the board of directors are for a period of three years. (Pls Ex. 15; Murphy 1599)

(98) Each component of the corporate membership has a nominating committee, or acts as a whole, to nominate corporate members to the board of directors. (Murphy 1498)

(99) Following nomination by the respective components of the corporate membership, the nominees to the board are voted on by the entire corporate membership. (Murphy 1565-1566)

(100) Consumer-group representatives on the board of directors come from groups of over 500 subscribers in the Detroit area and over 250 subscribers outside the Detroit area. (Murphy 1495)

(101) Past practice has been to include representatives of the five largest groups on the board of directors. These groups are Ford Motor Company, General Motors Corporation, Chrysler Corporation, Michigan Bell Telephone Company, and the Michigan Farm Bureau. (Murphy 1496)

(102) The current consumer representatives on the BCBSM board of directors are:

Clare J. Ackerman
Director of Operations
Seidman and Seidman

Frank Blackford
Past President
Macomb Community College

Thomas M. Bergeson
Director of Service Programs
Michigan Catholic Conference

Robert E. Braden
Administrative Director
Michigan Farm Bureau

Robert D. Brenner
Regional Director
Allied Industrial Workers
of America

Jacob Hurwitz
Senior Health Care & Insurance
Consultant
International Union-UAW

Wesley G. Jeltema
Executive V-President
Associated General Contractors

Walter Maher
Director-Employee Benefits
and Health Services
Chrysler Corporation

Beverley C. McDonald
Deputy Director
Michigan Legal Services, Inc.

'harles Chomet
roject Manager
'itizens for Better Care, Inc.

ohn B. Cook
ssistant Treasurer
ieneral Motors

ierald J. DeVore
'-President and Treasurer
Aichigan National Corporation

)onald F. Ephlin
'-President
nternational Union-UAW

tobert Fortney
'resident
:mployers Association of
Detroit

tussell A. Swaney
:conomic Consultant

tobert Walker
Administrator-Benefit Plans
Section
nternational Union-UAW

:dmund J. Whiting
Senior V-President
:x-Cell-O Corporation

John M. O'Hare
V-President
The Bendix Corporation

John W. Paynter
Business Consultant

Ellsworth G. Reynolds
President
Detroit College of Law

Jack K. Shelton
Manager-Employee Insurance Dept.
Ford Motor Company

Kenneth J. Shouldice
President Emeritus
Lake Superior State College

Jack H. Shuler
V-President
Michigan Bell Telephone Company

Jack Wood
Secretary-Manager
Detroit Building Trades Council

James W. Woodruff
President
Woodruff Oldsmobile

Donald E. Young
Executive V-President
Burroughs Corporation.

(103) Twenty-five (25) directors constitutes a quorum for meetings of the board of directors. (Pls Ex. 15; Murphy 1518)

(104) The current chairman of the board is James W. Woodruff, who was, originally, an Insurance Commissioner nominee. (Murphy 1499)

(105) Board member Frank Blackford is a former Insurance Commissioner. (Murphy 1505)

(106) The corporate membership attempts to balance sex, geography and race in the selection of directors. (Murphy 1549-1550)

(107) Current members of the board of directors, corporate membership, and management are permitted to suggest nominees and/or endorse nominees to the corporate membership and board of directors.

(108) Except as set forth in Finding 55, the method of selection of corporate members and directors has not been subject to governmental control. (Murphy 1509-1510)

(109) Except as set forth in Finding 55, the corporate structure and make-up has not been governmentally mandated. (Murphy 1509-1510)

(110) Provider representatives have not been selected based on the amount of claims generated by that provider group from BCBSM subscribers. (Murphy 1511-1512)

(111) BCBSM board minutes and committee minutes have not been available for general circulation to subscribers. (Murphy 1518)

(112) The board of directors has a number of standing committees which each meet several times a year. It would be extremely expensive to provide copies of the board and committee meeting minutes to each of BCBSM's over 2 million subscribers. (Murphy 1513, 1515-1518)

(113) No competent evidence was offered that would establish either that the current board of directors of BCBSM is, or is not, provider dominated.

(114) BCBSM has taken a number of cost containment actions over the past few years which are antagonistic to the interests of providers and which have resulted in lawsuits by the providers against BCBSM. (Benner 840-845) One of such

actions on the part of BCBSM has been the physicians reimbursement freeze in the high cost areas. (Chomet 2382-2383)

(115) Mr. Charles Chomet, a current BCBSM board member and an outspoken critic of the board, stated that he nevertheless votes with the majority of the board a majority of the time. (Chomet 2382)

(116) No competent evidence was presented indicating material conflicts of interest among past or present board members. What evidence was offered related only to Insurance Commissioner appointees.

(117) Evidence of the BCBSM loan to Chrysler was offered in what may have been an attempt to support an allegation of favoritism towards large BCBSM subscribers. No competent evidence was presented indicating that the directors acted other than in keeping with sincere belief that the loan would help save Chrysler and the thousands of jobs it provides. (Chomet 2404-2405, 2416-2417, 2430-2431)

(118) Representative Hollister, co-sponsor of HB 4555, the Bill which eventually became the vehicle for PA 350, represented to the Legislature that loans such as the Chrysler loan would be expressly *permitted* under HB 4555. (Def Ex. 77 p 9)

(119) The Insurance Commissioner has nominated at least seven persons to the board of directors of BCBSM. Mr. Chomet was the only one whose election or re-election was contested. (Murphy 1588-1590, 1600)

(120) Mr. Chomet was not removed from the board or corporate membership of BCBSM. He simply failed to win re-election after his term had expired. (Murphy 1560, 1562)

(121) At the corporate membership annual election meeting, a number of consumer and provider representatives spoke out in opposition to the re-election of Mr. Chomet. (Chomet 2336)

(122) The only reason expressed to Mr. Chomet as to the opposition to re-election was that the corporation felt he had

misused certain information by individually providing it to the media. (Chomet 2334-2335, 2337, 2423)

(123) Mr. Chomet's conduct was considered to be inconsistent with his duties as a director of BCBSM. (Murphy 1599-1600)

(124) The method of gubernatorial appointees to BCBSM's board of directors under PA 350 was chosen because it is the usual manner in which political appointments are made. (Pierce 3576)

G. BCBSM today—provider reimbursement

(125) Beginning in 1939, MHS (then MSGH) began by paying hospitals a flat per diem for hospitalization of MHS subscribers. (Bush 896)

(126) In 1946, with the departicipation of several hospitals due to inadequacy of the per diem reimbursement, a decision was made to adopt a system of reimbursing hospitals based on per diem allowable costs, determined on a retrospective basis. (Bush 896-897)

(127) "Allowable costs" excludes such items as research unrelated to patient care, bad debts, gift shops, parking lots, beauty shops, telephones and televisions. (Bush 897-898, 920-921)

(128) A community improvement factor was added to cost reimbursement sometime after 1946. The factor is additional payment to hospitals, the amount being 2 percent of inpatient costs and 6 percent of outpatient costs. (Bush 902-903)

(129) The community improvement factor was added to provide funds for improvement of facilities and equipment. The factor also recognized that the MHS reimbursement method did not necessarily pay for all hospital costs attributabe to MHS subscribers. (Bush 903-905)

(130) In 1959, faced with rising hospital costs, MHS introduced the Cost Increase Ceiling formula (CIC), which placed a

ceiling on how fast per diem costs would be permitted to rise on a yearly basis. (Bush 898-899)

(131) In 1968, MHS switched to the gross RCC system. (RCC stands for "ratio of charges to charges.") Under the gross RCC system, MHS would reimburse for the allowable costs of a hospital based on the ratio of charges for MHS subscribers to the total charges of a hospital (i.e., if 30 percent of the charges were attributable to MHS subscribers, MHS would reimburse the hospitals 30 percent of its allowable costs). (Bush 899-900)

(132) In 1974, the gross RCC system was modified to a departmental RCC system, whereby allowable costs were reimbursed on a department-by-department basis, again based on the ratio of charges attributable to MHS subscribers to the hospital's total charges for each department. (Bush 900-901)

(133) In 1975, BCBSM experienced a sharp rise in hospital costs and in 1976 imposed a 10 percent cap on all hospitals for the calendar year of 1976. This action by BCBSM spurred needed re-examination of the participating contract with hospitals. (Bush 905-907)

(134) In October, 1976, a new participation agreement with the hospitals was entered into which called for the creation of a 13-member hospital reimbursement committee charged with the responsibility of developing a new reimbursement method for hospitals. (Bush 908)

(135) The hospital reimbursement committee consists of 5 consumer members of BCBSM, 5 hospital representatives, and independent representatives to be appointed, one each, by the Governor, Senate Majority Leader, and the Speaker of the House. (Bush 908, 979)

(136) To date, the Governor has declined to appoint anyone to the hospital reimbursement committee as called for by the participation contract. His stated reason is: "It would not be proper for my appointees to be involved in both the private

negotiations between you and the hospitals and the process for public review and approval." (Pls Ex. 27)

(137) The hospital reimbursement committee developed the current Prospective Reimbursement System (PRS) which was phased in for all hospitals in 1978. (Bush 908-909)

(138) The PRS places a prospective limitation on a hospital in terms of how much its allowable costs will be permitted to increase during a given year. (Bush 901)

(139) The hospital reimbursement committee is responsible for establishing the allowable percentage increase for each hospital under the system, called the "Budget Screen." (Bush 909-910)

(140) Budget Screens are established several months prior to the beginning of a hospital's fiscal year so that the hospital can prepare its budget in conformity with the promulgated Screen. (Bush 909-910)

(141) Budget Screens apply only to the hospital's inpatient operating expenses, which constitute 84 percent of a hospital's operating expenses. The Screen does have an indirect impact on outpatient expenses as well. (Bush 986)

(142) The Budget Screen is set at anywhere between plus or minus 25 percent of the preceding four-year Michigan average in the rise of hospital costs. (Bush 911)

(143) The Budget Screen is not tied into any particular formula, but rather attempts to project trends in the economy. (Bush 911-912)

(144) Hospitals which set their budgets in excess of the Screen can elect budget review by a committee of one hospital representative, one BCBSM consumer representative, and one independent representative to ascertain whether such costs are justified. (Bush 910)

(145) At year end, BCBSM will not reimburse allowable costs in excess of the Budget Screen. If the hospital manages to

keep costs below the promulgated Screen, BCBSM will split the difference as an incentive payment to the hospital. (Bush 913)

(146) Actual cash payments to hospitals are made on a weekly basis based on estimates of yearly reimbursement. Adjustments based on actual allowable costs are made at the end of the year. (Bush 914)

(147) Initial Budget Screens under the PRS were set at 13 percent. Since then, the Screens have steadily declined to where the most recent Screen promulgated was 9.5 percent. (Bush 915)

(148) Due to some hospitals going through the budget review process, actual BCBSM payment increases to all hospitals have historically been 1-1½ percent above the promulgated Screen. (Bush 916)

(149) Not all hospitals electing budget review are given relief and, in fact, a hospital may be given a lower Screen than before if the review so indicates. (Bush 974)

(150) The Budget Screen does not apply to capital expenses which are generally fixed and do not increase from year to year. (Bush 983)

(151) BCBSM reimburses hospitals for *its share* of capital costs because if hospitals could not re-coup their capital costs, they would go out of business. (Feldstein 2213; Udow 304-308)

(152) The 2 percent community improvement factor is wholly independent of the Budget Screen and does not result in another 2 percent increase per year over and above the Budget Screen. (Bush 992-998)

(153) Hospitals view themselves as having financial requirements in excess of what BCBSM reimburses as allowable costs. Consequently, hospital charges are virtually always in excess of allowable costs. (Bush 920-921)

(154) The difference between hospital charges and what BCBSM defines as allowable costs, leads to a "differential"

between charges and BCBSM reimbursement levels. (Bush 920-921; Asmussen 1333)

(155) The hospital "differential" derives principally from the fact that BCBSM defines *allowable costs* as something less than *hospital charges*. (Asmussen 1333; Bush 923-924, 965)

(156) The hospital "differential" today is approximately 15 percent. Thus, BCBSM reimburses hospitals approximately 15 percent less than the hospital charges. (Bush 922)

(157) In 1981, that "differential" amounted to $245,000,000. The "differential" has been increasing historically. (Bush 922-923)

(158) Prior to the late 1960's MMS reimbursed physicians on the basis of a fixed fee schedule. (Bush 926)

(159) In the late 1960's, MMS switched to a Michigan Variable Fee (MVF) program whereby MMS would pay the *least* of three items for a given procedure: (1) the actual physician charge; (2) the customary charge of that physician for that procedure; and (3) the prevailing fee screen for that procedure, roughly the 90th percentile of all physician charges for that procedure. (Bush 926-927)

(160) Prior to the adoption of MVF, a participating physician could accept the BCBSM reimbursement amount, and, if the patient or the patient's family earned below a certain income level, then the physician was free to bill for the difference. A prime objective was to avoid situations where the subscriber was called upon to make out-of-pocket expenditures. (Bush 1096-1097)

(161) In 1972, a profile limitation factor (PLF) was added to the system which imposed a limit on how much any physician could raise his or her customary charge in any given year. (Bush 927)

(162) In 1979, the prevailing fee screen was switched to a maximum screen which would represent the maximum amount BCBSM would reimburse physicians for any given procedure.

These screens were then frozen in the high cost areas of the state. The maximum screens in the outstate areas were lowered from the 90th percentile to about 85 percent of charges. (Bush 928-930)

(163) Paying less than charges leads to a "differential" with respect to physician payments as with hospitals. In 1981, the "differential" between BCBSM payments and actual charges was $339,000,000. (Bush 932-933; Asmussen 1333-1334)

(164) "Fee-for-service" is a term which is generally used to describe a simple economic relationship in which payment is made for services rendered. The more services are provided or consumed, the more is paid for the provider of those services. In a fee-for-services arrangement providers benefit from increase utilization. (Rosen 2712; Feldstein 2230-2231)

H. Cost containment

(165) The overall corporate goal of BCBSM is to provide "service benefit delivery: where the subscriber is removed from the financial transaction between patient and doctor and suffers no out-of-pocket expense for certificate-covered services. (Asmussen 1325-1326, 1349)

(166) Achievement of the service benefit delivery goal is of utmost importance to BCBSM's customers. (Asmussen 1429-1433)

(167) Through the years, BCBSM and its predecessor corporations have been successful in providing service benefit delivery. (Asmussen 1326)

(168) The nature of the health care business today is significantly different than it was in 1939. (Asmussen 1359)

(169) Following the introduction of Medicare and Medicaid in the 1960's, everyone, BCBSM included, began experiencing dramatic rises in health-care costs. (Asmussen 1327)

(170) With the sharp rise in health-care costs, cost containment became a major objective of BCBSM in the 1970's. (Asmussen 1327)

(171) BCBSM has attempted to balance the issues of service benefit delivery, the need for participation, and cost containment. If one is too tough in terms of cost containment, then he or it is likely to lose participation on the part of providers. If one fails to provide a service benefit to the customer, the business is lost to other health carriers. (Asmussen 1327)

(172) It is a delicate balance between cost containment and maintaining service benefit delivery. (Asmussen 1349)

(173) The factors which go into overall health-care costs and the steady rise thereof are many and varied. Some of the more crucial factors which affect health-care costs in Michigan are the following:

a. The price for the services rendered, that is, the charge of a hospital or physician for services rendered (Manzo 1806-1808; Feldstein 2217-2219; Powsner 3187-3188);

b. Utilization of services by patients (Rosen 2685; Powsner 3154; Baerwaldt 3734-3735; Houghton 1169-1170);

c. The supply of providers in the system (Bush 946, 1101; Asmussen 1337-1338, 1350-1341);

d. The benefit design of certificates purchased by customers (Pierce 3556; Asmussen 1337-1338; Powsner 3186; Feldstein 2164);

e. Federal tax laws which encourage purchase of comprehensive first dollar health insurance (Feldstein 2133, 2167; Powsner 3187);

f. The high concentration of people with first dollar comprehensive coverage in Southeastern Michigan (Asmussen 1341-1342, 1414-1415; Feldstein 2222);

g. The high level of per capita income in Michigan (Feldstein 2164, 2167; Rosen 2705-2706; Pls Ex. 47 p 2);

h. Fixed labor costs in hospitals (Pls Ex. 47 p 2);

i. The incidence of high medical technology in Southeastern Michigan (Pierce 3550);

j. Excess hospital beds (Shelton 2789);

k. Cost shifts due to Medicaid and Medicare programs (Powsner 3185; Shelton 2930-2931);

l. Providing for administrative expenses and reserves of third-party payors and insurers (Manzo 1806-1808; Feldstein 2217-2219; Powsner 3187-3188).

(174) The main factor that characterizes the health-care economy in Michigan is the concern with health-care costs, how high they are and how radically they are increasing. (Feldstein 2132)

(175) The health-care field does not, and has not operated as a competitive market. (Feldstein 2132)

(176) When a competitive market is lacking, there is less incentive to be concerned with cost increases. (Feldstein 2135)

(177) As to rise in health-care costs, in 1981 Michigan experienced an over *15 percent increase* in *hospital costs* and approximately *19 percent increase* in *physician expenditures*. (Feldstein 2135)

(178) Historically, Blue Cross and Blue Shield have done an effective job in controlling *price* on the physician's side, but they have not been successful in controlling utilization.

(179) The combination of the BCBSM allowable price increase for physicians, which was 4.7 percent in 1981, combined with the physician utilization increase experienced in 1981, which was roughly 13 percent, led to a weighted average increase in physician costs for 1981 of approximately 19 percent. (Asmussen 1412) The 4.7 percent was below the general inflation rate. (Asmussen 1412)

(180) By adjusting maximum screens, BCBSM can limit the level of its reimbursement to physicians *for a given procedure*. (Bush 932; Asmussen 1334)

(181) Maximum screens are lowered on occasion. (Bush 931)

(182) Maximum screens in the "I-75 corridor" have been frozen at 1978 levels for the past four years. (Bush 931)

(183) The "I-75 corridor" refers to 13 counties which encompass the Detroit metropolitan area and up I-75 to Flint and Saginaw. This area has been identified as the highest care cost area in the State of Michigan.

(184) Without strong policies to contain costs of physician's services, both price of services and utilization of services, we can expect a rate increase like that of the last decade---approximately 11.3 percent per year compared to 9.2 percent for GNP. (Def Ex. 35 State Health Plan 1980-1984 p 680)

(185) The voluntary effort program and the reimbursement mechanisms being introduced by BCBSM and by the Michigan Medicaid program may have some moderating effect, but the magnitude thereof is impossible to predict. (Def Ex. 35 State Health Plan 1980-1984 p 680)

(186) Between 1975 and 1980, *total* hospital expenses in Michigan rose 88.2 percent. The national average for the same period was 97.2 percent. (Pls Ex. 28 Table X)

(187) Between 1978 and 1980, hospital *inpatient* expenses in Michigan increased at the fifth lowest rate in the nation. (Def Ex. 5 p 3)

(188) The State Health Plans have recognized the contribution of BCBSM's PRS to stemming the rise in hospital costs:

> "It is reasonable to conclude, however, that the rate of increase of expenditures will probably decline somewhat because of the full implementation of activities already underway. One obvious example is the prospective reimbursement system for hospitals that was a product of negotiations between the hospitals and Blue Cross and Blue Shield and which began in January of 1978." (Def Ex. 33 p 482; Def Ex. 35 p 610)

(189) The PRS also attempts to deal with overbedding by forcing low occupancy hospitals to take beds off line. (Bush 913)

(190) The State Health Plan for 1979-1983 recognized the contribution of BCBSM's PRS to the overbedding issues:

> "Blue Cross and Blue Shield of Michigan has developed a prospective reimbursement system which includes occu-

pancy rates as a factor in determining reimbursement. However, other third-party payors have not followed."

(Def Ex. 35 p 546)

(191) Increased utilization of health-care services results in overall increased costs. (Houghton 1169-1170; Rosen 2685; Powsner 3154; Pierce 3553; Baerwaldt 3734-3735; Asmussen 1340-1342, 1414-1415)

(192) BCBSM, as have Medicaid and Medicare, has had a difficult time controlling the utilization of medical services. (Asmussen 1337)

(193) The greatest difficulty in controlling utilization is that the ultimate decision as to whether a given procedure will be performed rests in the professional judgment of the health-care provider. (Rosen 2697; Pierce 3604-3605)

(194) Many medical decisions are in gray areas where it is difficult, if not impossible, to second-guess the professional judgment of the provider. (Asmussen 1340, 1412-1414, 1417)

(195) Doctors are not receptive to peer review, but if appropriately done, they are less antagonistic. Peer review is more readily accepted at this time than in the past. (Powsner 3230-3213)

(196) Two factors which impact utilization are the supply of providers and benefit design. BCBSM does not have direct control over either of these two factors. (Asmussen 1337-1338)

(197) The supply of providers and the utilization of services are directly linked together. (Bush 946, 1101; Udow 229)

(198) The supply of practicing physicians in Michigan exceeds the number required. (Asmussen 1412)

(199) Over the last few years—in the latter half of the 1970's—there has been approximately a 25 percent increase in the number of licensed physicians in Michigan while at the same time the increase in population has been only about 1.7 percent. (Asmussen 1412-1413)

(200) To control the supply of providers, BCBSM must principally rely on the state licensing and certificate of need programs, as well as the federal health planning agencies. (Bush 954-955)

(201) With respect to benefit design, it is widely recognized that the collective bargaining process in this State, demanding first dollar, comprehensive coverage, results in over-utilization of services and higher overall health-care costs. (Asmussen 1341-1342, 1414-1415; Feldstein 2164, 2222; Pierce 3556) (Benefit design is generally dictated to BCBSM by its customers.) (Asmussen 1337-1338; Shelton 2784)

(202) In Southeastern Michigan approximately 92 to 93 percent of the people have first dollar coverage for health-care services. (Asmussen 1341)

(203) First dollar coverage leads to greater utilization of health-care services. (Feldstein 2223)

(204) In Michigan, given the very strong preference that unions have for full coverage and first dollar coverage, in order to limit increasing health-care costs, more in the way of limiting utilization is in order. (Feldstein 2229)

(205) BCBSM does have a number of programs which attempt to control the utilization of health-care services. Among them are the following:

a. All participating hospitals must have utilization review committees or contract with outside organizations to conduct utilization review. (Udow 296; Bush 948)

b. BCBSM monitors the effectiveness of utilization review conducted by hospitals. (Bush 1005-1006)

c. BCBSM conducts utilization audits both on a random basis and on the basis of identified problems. (Bush 1007-1008, 1011)

d. BCBSM conducts utilization reviews to determine the medical necessity or appropriateness of a given procedure. (Bush 940, 947)

e. BCBSM has incentive programs designed to limit the lenth of stay in hospitals. (Bush 948)

f. It has incentive programs designed to result in utilization of the least costly alternatives. (Udow 269-270)

g. It has some pre-authorization programs designed to limit the utilization of certain services. (Bush 947; Udow 290)

h. It has programs which attempt to limit the unnecessary acquisition of very expensive medical equipment such as cat scanners. (Bush 954-955)

(206) BCBSM contends that it has been successful in utilization control on the hospital side. Dr. Paul J. Feldstein, faculty member at the School of Public Health, University of Michigan, responding generally testified that BCBSM has not been as effective in cost containment as an organization with its market share could be. (Feldstein 2172) He indicated further in reviewing the Blues' utilization review program, there are two separate issues: one is what it is they are doing, and the second is how effective they are in what they do. (Feldstein 2238)

(207) Admissions per 1000 population in Michigan was below the national average in 1975. (In 1975 the number was 152.42 while the average for all the states and the District of Columbia was 158.19.) Michigan was below the average as well in 1980. (Michigan total was 156.59, and average was 160.24.) (Pls Ex. 28 Table IV)

(208) As to average length of stay in hospitals, in 1975, Michigan ranked 9th amongst the states and the District of Columbia with 8.2. The average for 1975 was 7.7. In 1980, Michigan ranked 20th with 7.8. The average in 1980 was 7.6. (Pls Ex. 28 Table VII)

(209) BCBSM figures for both admissions per 1000 population and average length of stay are lower than the statewide figures for these factors. (Velky 3005)

(210) During each of the years 1970 through 1980, the number of hospital admissions per 1000 BCBSM members exceeded the equivalent for Blue Cross nationally. (Def Ex. 57 p D)

(211) During each of the years 1970 through 1980, the average length of hospital stay for BCBSM members exceeded the equivalent for Blue Cross nationally. (Def Ex. 57 p C)

(212) From 1975 to 1980, Michigan reduced the number of inpatient days per 1000 population from 17th in the country to 23rd in the country. (Pls Ex. 28 Table III)

(213) The utilization review conducted by BCBSM has achieved better results in hospital utilization than a state like New Jersey, which contracts with federal Professional Review Organizations (PSRO) for utilization review. (Manzo 1836)

(214) Comparing Medicaid utilization control efforts and results with BCBSM efforts and results is only somewhat enlightening. The supposed savings in the Medicaid program result in part from either benefit reductions where Medicaid simply states it will not pay, or from tie-in arrangements which would be illegal if attempted by BCBSM. Examples include: limitations of certain drug benefits (Rosen 2724); unilateral reductions in what Medicaid will pay physicians for certain services (Rosen 2725); unilateral institution of co-pays (Rosen 2726); unilateral reduction of reimbursement to county medical care facilities (Rosen 2727); unilateral reduction of reimbursement to hospitals (Rosen 2729-2731); and volume purchase of drugs and eyeglasses with tie-in arrangements with physicians who prescribe for Medicaid patients. (Rosen 2734-2735)

(215) In 1980, the Medicaid budget was 1.2 billion dollars. In 1981, the budget was 1.35 billion dollars. Despite several cut-backs in benefits, the Medicaid budget increased nearly 10 percent from 1980 to 1981. (Rosen 2738)

(216) Over certain factors which drive up the cost of health care in Michigan, BCBSM has no control. These include:

a. Federal tax laws which encourage the purchase of comprehensive first dollar coverage (Feldstein 2133; Powsner 3187);

b. Higher per capita income levels in Michigan. Michigan is in the top five states in terms of per capita income. There is a direct correlation between higher income and higher health care costs (Feldstein 2164, 2167; Rosen 2705-2706; Pls Ex. 47 p 2);

c. Excess hospital beds. This is controlled by the State under the certificate of need program. (Powsner 3209, 3221; Shelton 2789; Def Ex. 35 p 669-671)

d. Cutbacks in Medicaid and Medicare which may shift costs to other payors such as BCBSM (Powsner 3185; Shelton 2930-2931);

e. Fixed labor costs in hospitals which in 1978 were 17.8 percent higher in Detroit than the national average of major metropolitan areas. Such labor costs constitute 60% of the hospital's per diem costs. (Pls Ex. 47 p 2)

f. High medical technology (Pierce 3550).

(217) BCBSM has other cost containment programs which attempt to counteract these factors. Some of these programs are:

a. Facility controls such as the PRS and financial audits;

b. Physician controls such as the freeze on maximum screens in the high cost areas;

c. Participation in state and health planning agency decisions concerning the supply of providers;

d. Review of medical necessity and benefit eligibility;

e. Cost avoidance programs such as discouraging use of inpatient facilities when a procedure can be performed on an outpatient basis, discouraging use of hospital emergency rooms and discouraging weekend admissions. (Bush 944-949, 957-963)

(218) In June of 1979, BCBSM caused the Chairman of the House Insurance Subcommittee to be informed that BCBSM's

cost containment programs during 1978 had accomplished savings of $466,653,404. (Pls Ex. 57)

(219) In 1980, BCBSM's "cost containment programs" saved $588,840,061. (Def Ex. 4 p 8)

(220) In 1981, "cost containment programs" saved $823,719,880. (Def Ex. 3 p 8)

(221) $399,100,000 of that 1981 saving of $823,719,880 is said to have been accomplished through "professional cost controls." These savings are attributable to the ability of BCBSM to contract with providers. Another $76,235,050 in savings is said to have derived from "review for medical necessity and benefit eligibility." This activity is something any commercial insurer or efficient company would do. "Recoveries from other insurers" (coordination of benefits) (alleged savings of $33,514,640) fits into the same category of being something any reasonably efficient company would do. (Def Ex. 3 p 8; Bush 967-970)

(222) The testimony is conflicting as to whether BCBSM has taken reasonable steps over the past few years to control utilization.

(223) The large market share of BCBSM in the past has made it less concerned with utilization (and in turn costs and health care costs) than had the market been more competitive. BCBSM has not been as effective in cost containment as an entity with its market share could be. (Feldstein 2135, 2172 and total record)

I. BCBSM's place in the market and health care costs

(224) During the year ending December 31, 1981, BCBSM had 65.56 percent of the accident and health insurance business in Michigan. (Def Ex. 61 p 37)

(225) BCBSM covers approximately 4.9 million of the approximate 9.1 million people in the State of Michigan. (Velky 3002-3003; Baerwaldt 3403)

(226) The 4.9 million figure represents approximately 2 million subscribers of BCBSM since there are generally 2 to 2-1/2 family members per subscriber. (Wilkinson 176-177; Def Ex. 3 p 2)

(227) In 1977 BCBSM covered 58.5 percent of the population of the State, and in 1978 it covered 58 percent. (Def Ex. 128 p 4; Def Ex. 129 p 4)

(228) Over half of the persons covered by BCBSM are in groups of over 2500 subscribers. (Def Ex. 3 p 3)

(229) BCBSM's penetration in terms of subscribers enrolled varies greatly throughout the state, from well over half of the population in the Detroit Metropolitan area down to 9 to 10 percent in the Upper Peninsula. (Asmussen 1328-1329)

(230) In 1981, BCBSM incurred approximately 2.6 billion dollars in health care claims on behalf of its subscribers. (Def Ex. 1, fourth page)

(231) In 1980, approximately $1.5 billion of the $3.5 billion total hospital expenses in Michigan were paid by BCBSM. (Velky 3047; Pl Ex. 28 p 3)

(232) In 1978, BCBSM payments to hospitals accounted for approximately 63 percent, and payments to physicians 25 percent, of its total payouts. (Shelton 2850; Def Ex. 51)

(233) In 1980, the hospital *admissions* per 1000 population in Michigan was lower than the national average. The admissions of BCBSM members was higher than the average of members of Blue Cross nationally.

Michigan	156.59	
U.S. average	160.24	(Pls Ex. 28 p 3)
BCBSM members	125	
Blue Cross nationally	117	(Def Ex. 57 p D)

(234) In 1980, the number of hospital *inpatient days* per 1000 population in Michigan was higher than the U.S. average.

Michigan	1,225	
U.S. average	1,211	(Pls Ex. 28 p 3)

(235) In 1980, the average *length of hospital stay* for BCBSM members in Michigan was longer than that of Blue Cross Plan members nationally.

Michigan	6.83	
Blue Cross nationally	6.24	(Def Ex. 57 p C)

(236) Each year from 1970 through 1980, the average length of hospital stay for BCBSM members in Michigan was longer than that of Blue Cross Plan members nationally. (Def Ex. 57 p C)

(237) In 1980, the hospital *expense per adjusted patient day* in Michigan was greater than the U.S. average.

Michigan	$267.28	
U.S. average	245.12	(Pls Ex. 28 p 3)

(238) The 1980 hospital *expense per capita* in Michigan was over that of the U.S. average.

Michigan	$382.87*
U.S. average	340.72

* This was an 84.8 percent rise over 1975. (Pls Ex. 28 p 3)

(239) The hospital expense per capita as a percent of per capita income in 1980 was:

Michigan	3.85
U.S. average	3.57

This constituted an 11.6 percent rise over 1975. (Pls Ex. 28 p 3)

(240) The 1980 Michigan *cost per adjusted admission* was higher than the U.S. average.

Michigan	$2,086.52	
U.S. average	1,850.96	(Pls Ex. 28 p 3)

(241) The *total hospital expenses* in Michigan in 1980 were $3,539,256,000. This was 88.2 percent higher than the 1975 total expenses. (Pls Ex. 28 p 3)

(242) Some caution must be exercised in attempting to compare health care costs in Michigan with costs in other states

because of wide variation in terms of benefits offered, hospital and professional differentials, reimbursement methods, and levels of penetration. (Feldstein 2186; Velky 3049-3050; Shelton 2896; Houghton 1166)

(243) BCBSM offers one of the most comprehensive benefit packages of all of the Blue plans around the country. (Velky 3050)

(244) In comparing health care costs, it is equally relevant to consider not only actual expenditures, but expenditures as a percent of per capita income as well. (Pierce 3613; Rosen 2705-2706)

(245) Information supplied the Legislature prior to the adoption of 1980 PA 350, included the following:

a. In 1969, Michigan was 4 percent above the national average in per capita expenditures for physician services. (Pierce 3601; Pl Ex. 51, Table 1)

b. In 1980, Michigan was 10 percent above the national average in per capita expenditures for physician services. (Pls Ex. 51, Table 2)

c. In 1978 Michigan had a per capita expense for hospital services of $301.57 while the national average was $266.99 (Pls Ex. 51 Table 5)

d. In 1977 and 1978, Michigan was 5.2 percent above the national average in per capita expenditures for all health care services. (Pls Ex. 51 Table 6)

(246) Data comparing the health care costs of Ford Motor Company in the Southeastern part of Michigan to certain selected areas where Ford conducts business was distributed to members of the Legislature by Senator Pierce. (Def Ex. 95)

(247) The Ford Motor data should be considered with the following in mind:

a. Michigan Ford employees are located principally in the Southeastern part of the State. This area has the

highest health care costs in the State. (Shelton 2607, 2869-2870)

b. Utilization of services by Ford employees is higher in Southeastern Michigan than in other states. (Shelton 2833)

c. The data compares, in part, Southeastern Michigan costs to those of New York and New Jersey where hospital rates are set by the government. (Shelton 2836-2837)

d. The data does not look to all states, but rather 14 states.

(Def Ex. 95)

(248) The numbers shown on the spread sheet (of Defense Exhibit 49) relate to the costs of Blue Shield coverage for ten members.

(249) The dollar figures presented in the Ford data relating to costs for Blue Shield coverage reflect ten members. (Shelton 2781)

(250) Pierce admittedly did not present complete Ford data to the Legislature, but rather data which would best emphasize his position. (Pierce 3473)

(251) When Senator Pierce received comparative data from General Motors, he extracted the most unfavorable comparative data and did not distribute the remainder of the information. (Pierce 3557-3559)

(252) With respect to the General Motors data Senator Pierce did distribute, he testified: "I think it was unfair of me and I can tell you that Table 3 is not a complete enough piece of information." (Pierce 3561)

(253) The General Motors data reflects health care costs in areas of the State other than the Southeastern portion.

(254) The General Motors data reflected:

a. For hospital expense per hourly employee, Michigan ranked 8th in 22 states. Additionally, 7 states below Michigan were within 11 percent of Michigan.

b. For prescription drug expense per hourly employee, Michigan ranked 6th out of 22 states.

c. For the total expense per hourly employee, Michigan ranked 6th out of 22 states. Additionally, 6 states below Michigan were within 11 percent of Michigan.

(Def Ex. 100)

(255) Senator Pierce requested from Chrysler only data relating to three of the states where Chrysler does business. Additionally, he removed from that data explanatory material which showed varying direct labor costs for hospitals in those areas which differed by as much as $71 per day. (Pierce 3592; Pls Ex. 48)

(256) The Attorney General represented to the Legislature in March of 1979:

> ". . . in October of 1976, General Motors paid a combined composite Blue Cross/Blue Shield rate of $107.40 per month for each Michigan hourly employee. By contrast, General Motors paid $43.71 per month for each hourly employee in the Wilkes-Barre area of Pennsylvania. This difference of $63.69 per month per hourly employee means that it costs General Motors, in 1976, 146 percent more to insure an hourly employee in Michigan than a comparable employee in Wilkes-Barre, Pennsylvania."
>
> (Def Ex. 109 p 2-3)

(257) No specific evidence was introduced to the effect that BCBSM coverage has become unaffordable to any BCBSM subscribers. However, judicial notice is taken of the currently existing high unemployment and also of the growing number of retired citizens with limited incomes.

(258) The increase in hospital costs in Michigan last year (1981) was over 15 percent. Physician expenditures rose 19 percent. (Feldstein 2135)

(259) The Co-Director of Michigan Citizens Lobby advised the Legislature in May of 1979 that health care rates and costs

were rising at "double the pace of inflation in the rest of the economy."

(260) On May 6, 1980, the Attorney General advised the Legislature that BCBSM had filed for Blue Cross rate increases to be effective beginning July 1, 1980, but that because the Insurance Commissioner had no authority over Blue Shield rates, Blue Shield can charge whatever it likes. (Def Ex. 83 p 2)

(260-A) Finding (522) at pages 95-96 is appropriate at this point.

J. ASO

(261) The phrase Administrative Services Only (ASO) refers to an arrangement whereby a health-care coverage customer is self insured and pays claims plus an administrative fee, as opposed to paying a flat insurance premium. (Wilkinson 70) This type of arrangement is sometimes referred to as "cost plus." (Henry 2970)

(262) Section 211 of PA 350 prohibits ASO arrangements for groups of under 500 subscribers except that a health care corporation may continue administrative services only arrangements with subscriber groups of less than 500 where the arrangements were in existence in September, 1980. (Wilkinson 90, 98; Henry 2970)

(263) PA 350 places the following restrictions on ASO arrangements for groups of over 500 subscribers which restrictions are not placed on the competitors of BCBSM:

a. Requires prior approval of all benefit changes;

b. Requires inclusion of all legislatively mandated benefits;

c. Requires prior approval of the administrative fee to be charged to ASO customers.

(Wilkinson 90-92, 101; Dewenter 25)

(264) The danger in marketing ASO business to groups of under 500 involves fluctuation of claims which is directly

related to the size of the group. The smaller the group, the more probability one is going to have of a greater variation in the claims that are going to be incurred by that group. Thus, if one had a group of 2,000, and a substantial claim was incurred, such claim may not materially affect the results overall of that group, whereas a substantial claim for a group of 100 may put an extreme financial burden on that group. (Henry 2976-2977)

(265) A small group which experiences a substantial claim, which in turn results in an extreme financial burden on that group, runs a risk of insolvency which could then work its way back into having an effect on BCBSM. (Henry 2977)

(266) BCBSM has been marketing ASO arrangements since 1979. (Wilkinson 75-76)

(267) The Insurance Bureau has never approved of BCBSM's ASO activity; neither has it taken or initiated any action to stop BCBSM from entering into ASO arrangements. (Baerwaldt 3749-3750)

(268) On all Michigan accounts, BCBSM requires an ASO customer to make an advance deposit to BCBSM in the amount of 30-50 days worth of claims, to provide funds for the payment of claims. (Wilkinson 131-133, 154-155; Henry 2989)

(269) National accounts which are on an ASO basis are also required to make an advance deposit to BCBSM for payment of claims. (Dewenter 27-28; Wilkinson 154-155)

(270) For national accounts, BCBSM receives a "control plan" fee on top of the ASO administrative fee. (Wilkinson 111-112)

(271) The administrative fee charged the ASO customer is a negotiated amount from customer to customer, and may be calculated on a percentage of claims or a per-member basis. (Wilkinson 71, 159; Dewenter 17-18)

(272) As a matter of marketing policy, BCBSM does not enter into ASO arrangements with groups of under 100 subscribers. (Wilkinson 79, 127-128)

(273) As a matter of marketing policy, BCBSM requires ASO groups under 1000 subscribers to purchase a form of commercial stop-loss coverage to protect against abnormally high claims. This insurance coverage applies to total claims, total of an individual claim, or both. (Wilkinson 72-73)

(274) Stop-loss protects BCBSM, the customer, and members of the customer's group. (Wilkinson 73-74, 97)

(275) The benefit structure in an ASO arrangement is based on individual negotiation with each customer. (Dewenter 13)

(276) Due to BCBSM's contractual relationship with providers, once a claim is incurred, BCBSM must reimburse for that claim, regardless of whether the ASO customer is able to reimburse BCBSM for such claims. The member of an ASO group is thus protected the same as if full insurance had been purchased. (Wilkinson 72, 80)

(277) If a small group under an ASO arrangement incurred unusually high claims, and if the deposit towards claims was inadequate, and if the stop-loss insurance coverage was insufficient, and if the employer was insolvent, then BCBSM would be required to come forward with funds with which to pay providers. (Wilkinson 122)

(278) BCBSM has not been called upon to expend any moneys under the circumstances set forth above. (Wilkinson 122)

(279) BCBSM offers the same services to ASO customers as to fully insured customers and the services are offered on an equal basis regardless of the size of the group. (Wilkinson 84, 86)

(280) ASO customers contribute to BCBSM reserves. (Wilkinson 87-88, 140)

(281) On *total* ASO business for the year ending December 31, 1981, BCBSM had premiums earned of $98,944,188, claims incurred of $93,256,522, and expenses incurred of $6,755,109, for a loss of $1,067,473. (Def Ex. 1 "Exhibit 5"; Wilkinson 119)

(282) Each ASO contract is renewed on an annual basis. (Wilkinson 83)

(283) The renewal month for ASO customers varies from group to group. (Pl Ex. 17; Pl Ex. 18)

(284) There is a dramatic trend in this country toward ASO arrangements. (Houghton 1172)

(285) BCBSM studies indicate a trend to ASO in Michigan and predict that 18-40 percent of current groups will convert to ASO within the next few years. (Wilkinson 93-94)

(286) Group customers find ASO arrangements preferable to full insurance for the following reasons:

a. The customer avoids contributing to the large reserve requirements of an insurer which are unrelated to ASO arrangements.

b. ASO improves a customer's cash flow position.

c. ASO offers the customer a better means of controlling its own group experience.

(Wilkinson 87, 89-90, 101-102; Houghton 1172-1174; Dewenter 15-16, 18, 20, 22, 32, 37-38; Pls Ex. 53)

(287) ASO arrangements have proven to be less costly to customers than full insurance. (Dewenter 20, 26)

(288) BCBSM has over 25 ASO contracts with groups of under 500 subscribers which were entered into after September of 1980. (Pls Ex. 40)

(289) Prohibiting ASO for groups of under 500 subscribers will cause BCBSM an estimated loss of 80 million dollars each year in premiums. (Wilkinson 94)

(290) Currently there are commercial insurance companies and third-party administrators in the State of Michigan writing ASO contracts. (Wilkinson 92; Houghton 1171-1172; Baerwaldt 3318)

(291) The commercial insurance companies may not write ASO's for groups of less than 500 employees and members. (Baerwaldt 3319-3320; 1981 PA 189)

(292) Requiring BCBSM to include mandated benefits in its ASO contracts while not imposing the same restrictions on other organizations providing ASO services puts BCBSM at a competitive disadvantage. (Houghton 1174-1175; Dewenter 17)

(293) Generally, hospital claims amount to approximately 60 percent of all claims. BCBSM receives a 14.8 percent differential on hospital claims which it passes on to its ASO accounts. (Wilkinson 143-146, 165, 179)

(294) No competitor of BCBSM in the ASO market receives the differential, and therefore BCBSM enjoys a substantial advantage in the ASO market. (Wilkinson 147-148, 179-180)

(295) Because ASO contracts are often obtained on a "bid" basis, requiring prior approval of the administrative fees by the Insurance Commissioner may preclude the submission of timely bids. (Wilkinson 93)

(296) The Insurance Commissioner has taken the position that she has no regulatory authority over ASO contracts written by commercial insurance companies. (Baerwaldt 3788-3789)

(297) BCBSM has 358 groups enrolled in the *over* 500 subscriber category. (Def Ex. 3 p 3)

(298) BCBSM has 57 groups of over 500 enrolled on an ASO arrangement. (Pls Ex. 17)

(299) Potential losses to BCBSM due to restrictions placed on ASO arrangements by PA 350 for groups *over* 500 subscribers is estimated at 300-400 million dollars per year. (Wilkinson 99-102)

(300) Loss of subscriber base due to restrictions on ASO arrangements will lessen BCBSM's ability to continue to negotiate with hospitals and other providers in cost containment efforts.

K. Packaging

(301) "Packaging" refers to an arrangement whereby an individual, or an employer, or group of individuals purchase related insurance lines from a single representative to achieve cost and administrative efficiencies. (Abel 412-413)

(302) Section 206(4) of PA 350 forbids a health care corporation marketing or transacting any type of life insurance.

(303) In the past, and prior to PA 350, BCBSM challenged the authority of the Insurance Bureau to prohibit packaging of life insurance in conjunction with health care coverage. (Baerwaldt 3315)

(304) PA 108 and 109 was silent in regard to a health care corporation engaging in the sale of life insurance. (Baerwaldt 3748)

(305) The Insurance Commissioner argued before the Legislature, before the passage of PA 350, that to permit BCBSM to package life insurance would "depart from the purpose of [PA] 108 and 109." (Baerwaldt 3748-3749)

(306) A representative of the Michigan Citizens Lobby testified before the Legislature, before the passage of PA 350, that it was inappropriate for the state-conferred subsidy and advantages of BCBSM to be used to gain a market share in the life insurance area, and that MCL feared monopolistic results (Tuchinsky 2038)

(307) It is the belief of the Insurance Commissioner that the life insurance market is very competitive with the largest company (Metropolitan) holding only about 9.56 percent; that BCBSM representatives and BCBSM's marketing talents have aided in capturing for BCBSM 65.56 percent of the health-care market; and that if BCBSM is permitted to package life insurance, ultimately their market share for group life insurance could approach, through the packaging arrangement, 65 to 66 percent. (Baerwaldt 3353-3354, 3401, 3383-3384; Def Ex. 61 p 38)

(308) The Insurance Commissioner believes that there are some 15,000 life insurance agencies who presumably could be "monopolized" out of jobs if BCBSM continues to package. (3353-3354) The belief is sound.

(309) If BCBSM is permitted to sell life insurance other entities that sell life insurance would be at a competitive disadvantage. (Feldstein 2139)

(310) Life insurance representatives conveyed to the Legislature that one cannot buy health coverage from a commercial carrier without life insurance as a part of the package because that's what keeps the commercials in the health-care market. The Legislature was implored not to upset the balance evolving since 1939 that has assured competition. (Def Ex. 84)

(311) Packaging has been around since the 1950's. In the early years, BCBSM sales representatives would simply have another insurance agent call on customers with them to present a complete benefit package. (Abel 413-414)

(312) In the early 1960's, with increased demand, an informal relationship was entered into between BCBSM and Phoenix Mutual Insurance Company whereby Phoenix agents would accompany BCBSM sales representatives to present individual proposals at the same time. (Abel 414)

(313) By the late 1970's, the arrangement with Phoenix was proving insufficient to meet market demands. Research into BCBSM cancellation records by an independent data research company indicated large losses of group business due to BCBSM's inability to offer a packaged program. (Abel 415-416)

(314) BCBSM surveys similarly indicated a significant loss of business due to the inability to package. (Abel 425-426)

(315) BCBSM decided to form the Blue Ribbon Insurance Agency as a wholly-owned subsidiary of BCBSM, to have BCBSM representatives licensed to sell other forms of insurance, and then to offer a packaged program through Blue Ribbon. (Abel 416)

(316) Blue Ribbon was incorporated on January 1, 1979. An agency license was applied for in February, 1979, but never issued. (Abel 418, 423-424)

(317) Blue Ribbon has never offered for sale or marketed insurance of any type. (Abel 524)

(318) In April of 1979, a formal request was made to the Attorney General to issue an opinion on the authority of BCBSM to engage in packaging. No opinion was ever issued. (Pls Ex. 20, p 17; Baerwaldt 3781-3782)

(319) After failing to receive a license for Blue Ribbon, BCBSM explored other means of satisfying the market demand. Ultimately, it decided upon an arrangement whereby American Bankers Life Assurance Company of Florida (ABL) would open a branch office in Michigan and BCBSM sales representatives would become licensed to sell ABL insurance. (Abel 428-429)

(320) ABL was selected by BCBSM because ABL is willing to underwrite any risk that BCBSM will cover; ABL is licensed to sell insurance in Michigan; ABL marketing philosophies are consistent with those of BCBSM; and ABL is not marketing health care insurance. (Abel 432-433)

(321) ABL is willing to accept groups without proof of insurability, the same as BCBSM. (Abel 434; Scott 564, 573)

(322) ABL has similar arrangements with other Blue plans around the country, and has been packaging with Blue Plans since 1967. (Abel 433; Scott 560)

(323) ABL currently is affiliated with 25 Blue Cross Plans in packaging life insurance. (Scott 558) Blue Cross Plans in 38 areas have formal packaging arrangements. (Abel 429, 532)

(324) ABL also offers group conversion rights to an individual when he or she leaves a group with no requirement of proof of insurability. (Scott 594)

(325) No proof was submitted to the contrary, and the witness Scott testified that ABL had never failed to pay any

valid insurance claim. (Scott 689-690) It has never been found to have violated any law in the State of Michigan. (Baerwaldt 3840-3843)

(326) By letter dated June 28, 1979, BCBSM informed the Insurance Commissioner of the arrangement entered into with ABL. (Pls Ex. 20 p 13-14)

(327) The ABL branch office was opened in July of 1979, and by September or October of 1979, BCBSM sales representatives had been licensed by the State to market ABL insurance. (Abel 431)

(328) No legal actions have been commenced by the Insurance Commissioner to bring to a halt BCBSM's packaging activities. (Baerwaldt 3749-3750)

(329) Currently, BCBSM representatives who are duly licensed by the State to market other forms of insurance, are authorized to offer group life, accidental death and dismemberment, short-term disability, long-term disability, dependent life and travel accident along with BCBSM health coverage. (Abel 434-435)

(330) Prior to August of 1981, BCBSM sales representatives were paid standard commissions directly by ABL for insurance sold. (Abel 469, 471)

(331) There are currently about 60 BCBSM sales representatives licensed to market other forms of insurance. (Baerwaldt 3344)

(332) There is no requirement that in order to obtain BCBSM coverage one must purchase other types of insurance, and if the customer does not want BCBSM coverage, then the representatives will not offer the other lines. (Abel 436)

(333) In the Spring of 1981, Blue Ribbon purchased 50 percent of an existing Royal Oak, Michigan insurance agency (Associated Insurance Agency). Associated acts as the conduit between the insurance underwriters and the BCBSM representatives. (Abel 438) It was felt that it would be more economical

for ABL to pay a standard agency commission to Associated rather than maintain a branch office in Michigan. (437-438)

(334) Associated is a duly licensed insurance agency with the State of Michigan. (Abel 438)

(335) Associated officially opened for BCBSM packaging business in August of 1981. (Scott 592)

(336) ABL, or other carriers, now pay a standard agency commission directly to Associated. BCBSM receives no commission payment. (Abel 439)

(337) Associated pays to BCBSM sales representatives a portion of the agency commission received from ABL or other companies. (Scott 592)

(338) Insurance bills are paid directly to the underwriting company, and claims are processed directly by the underwriting company. (Abel 440-441)

(339) No assets of BCBSM are at a risk with respect to any insurance written by ABL. (Scott 690)

(340) There is convenience and cost saving to employers in purchasing a packaged program. Insurance is confusing, and by packaging, the employer narrows his inquiries and dealings to one (or a few) people representing insurers. Eligibility and waiting periods are more likely to be the same. Less burden is placed upon the employer's personnel department since it is not called upon to interpret numerous insurers' practices. (Abel 441-442; Scott 571; Baerwaldt 3391-3392)

(341) Packaged programs are primarily attractive to small employers since large employers have more bargaining strength and can pretty well negotiate effectively themselves with various insurance companies. (Abel 444-446, 512)

(342) BCBSM currently has 973 groups who have purchased package programs, with the average group size being 13 employees. (Abel 444)

(343) BCBSM sales of package programs represent approximately 3.1 million dollars of annualized premiums. (Abel 447)

(344) The demand for packaging continues to increase. (Abel 448)

(345) The inability to offer a packaged program will cause losses to BCBSM, both in terms of losing existing customers and in terms of not attracting new customers. (Abel 449-450; Cordon 402, 404)

(346) Estimated losses to BCBSM from the inability to package approximate 22 million dollars per year. (Abel 449-451)

(347) Loss of health care customers due to inability to package will adversely impact upon BCBSM's bargaining power with providers. (Pls Ex. 20)

(348) Approximately 323 companies write group life insurance in Michigan. (Baerwaldt 3348)

(349) In 1978, Metropolitan Life Insurance Company had the greatest share of the life insurance market with 9.56 percent. (Baerwaldt 3277; Def Ex. 61 p 38)

(350) In 1980, ABL issued for group life in Michigan 66.864 million dollars coverage. This represented 0.57 percent of the group life market and a ranking of 24th highest in Michigan. (Def Ex. 75; Baerwaldt 3349)

(351) Of the numerous companies domiciled in Michigan, only two (Macabees Mutual with 1.73 percent and League Life with .61 percent) had market shares exceeding that of ABL. (Baerwaldt 3350)

(352) In 1980, the Blue Cross Blue Shield share of the health care market, the ABL share of the group life market, the ranking in the state, and the year ABL commenced packaging with Blue Cross and Blue Shield in certain states is demonstrated as follows:

Plan	*BC/BS Share of Market*	*ABL Share of Market***	*ABL Ranking in State*	*Year ABL Commenced Packaging*
Oregon	22.7%	4.8%	6th	1976
Indiana	37.7	4.4		1974
Wisconsin	31.3	4.0	9th	1974
Utah	20.9	2.5	13th	1975
Florida	15.7	1.3	16th	1974
North Carolina	34.1	1.1	18th	1976
Tennessee	40.2	1.1		1974
Washington	19.5	0.8		1976
Virginia	41.4	0.6		1976

(Pl Ex. 23; Baerwaldt 3352; Scott 576-587)

** Refers to the percentage of group life insurance that was written as new business during 1980. (Scott 585)

(353) In Oregon, Indiana, Wisconsin, and Utah, where Blue Cross and Blue Shield have packaged group life insurance with ABL, in a relatively few number of years, ABL has captured sizeable portions of the group life market.

(354) This Court is without sufficient facts from which it could conclude that the Insurance Commissioner's fear expressed in Finding (307) is without merit.

(355) In 1981, the 20th largest writer of group life in Michigan wrote 7 times the volume of ABL. (Baerwaldt 3398)

(356) Except such as may exist by reason of packaging with BCBSM, ABL has no advantage over other commercial insurers operating in this state. ABL pays the same taxes and commissions as any other commercial insurance company. ABL sets its premium rates in the same manner as any other commercial insurer. (Scott 587-588, 593-594A; Baerwaldt 3381-3382)

(357) No evidence of possible or likely harm to BCBSM if it engages in packaging was presented.

(371) During 10/1/78 and 9/30/79, the occupancy rate for state-owned psychiatric hospitals, excluding the Northville Regional Psychiatric Hospital, was 76 percent. (Def Ex. 16, p 20)

(372) There are approximately 2,672 inpatient psychiatric beds in private institutions available in the State of Michigan.

(373) No evidence was presented that there is an insufficient amount of private beds available for acute psychiatric care.

(374) "Acute care" means care that is non-rehabilitative. (Udow 253)

(375) Most inpatient days in state psychiatric hospitals are on an involuntary basis. (Udow 233)

(376) The State attempts to recover for acute care from patients and/or their carriers for nursing personnel, full-time equated; medical staff, full-time equated; other professionals, full-time equated; non-technical, full-time equated; indirect costs, food service, housekeeping, laundry/clothing, clinics, clinical lab, dental, EEG, EKG, X-ray, physical therapy, drug/pharmacy, specialists, special education, general administration, program administration, and fringe benefits. (Winter 1894-1895)

(377) State psychiatric hospitals are supported in part by tax dollars, some of which come from BCBSM subscribers. (Winter 1925-1926)

(378) If Section 401(7) of PA 350 becomes effective it will result in BCBSM paying to the State of Michigan approximately 4.4 million dollars in additional payments in the first year and 28.55 million dollars in the first five years. (Udow 231-234; Winter 1873, 1885-1886)

L. (2) Freestanding facilities

(379) "Freestanding facilities" refers to non-hospital facilities. A freestanding surgical facility is a non-hospital ambulatory surgical facility. (Udow 238, 271)

(380) BCBSM does not currently participate with non-hospital, freestanding surgical facilities. (Udow 237, 238)

(381) BCBSM believes:

a. That there is more than adequate surgical capacity existing in hospitals today; (Udow 240, 271)

b. That non-hospital freestanding surgical facilities have capital costs which must be recovered (charged for) just like hospitals, (Udow 271-272; Shelton 2918) which will simply add a new layer of cost; (Udow 272)

c. That non-hospital freestanding surgical facilities will grow in number whether needed or not; (Udow 246)

d. That while it is generally less expensive to have a procedure performed on an outpatient basis as opposed to an inpatient basis, it is more costly to BCBSM if the procedure is performed at a non-hospital facility as opposed to the outpatient portion of a hospital. This is so because BCBSM reimbursement mechanisms force BCBSM to continue to pay its share of the fixed costs of the hospital regardless of whether the procedure is performed there or not; (Udow 246, 271-273, 279-280, 306)

e. Since non-hospital, freestanding surgical facilities provide for mostly elective surgery, with an increase in such facilities, there will be an overall increase in the number of surgical procedures performed. (Udow 246)

(382) There is more than adequate surgical capacity existing in hospitals today.

(383) Non-hospital freestanding surgical facilities will have to recover capital costs, and *some* of such capital costs will ultimately be paid by subscribers of BCBSM.

(384) That non-hospital freestanding surgical facilities will grow in number whether needed or not has not been demonstrated.

(385) Non-hospital freestanding surgical facilities would be less expensive, i.e., could charge less than hospitals, because the overhead would be less. (Shelton 2889)

(386) Inpatient surgery is more expensive than surgery performed in hospital outpatient facilities or freestanding facilities. In Arizona, where freestanding surgery centers exist, there was a 14 percent shift from inpatient to outpatient surgery. (Udow 274-275, 311-312; Feldstein 2206)

(387) BCBSM's hospital reimbursement mechanisms have been developed over many years. They do obligate BCBSM to pay a share of the fixed costs of the hospital.

(388) Allowing participation by freestanding surgical facilities will result in increased competition and innovation. (Feldstein 2156, 2207-2211)

(389) While the testimony is conflicting as to whether the presence of freestanding facilities will increase the number of surgeries (Udow 246; Feldstein 2889), it is concluded that certain types of procedures will increase in number.

(390) Senator Pierce argued to his colleagues that it was only fair that if the Blues were going to reimburse a facility owned by a hospital, that it also reimburse a facility owned by a physician or an individual or a group of individuals who are not physicians. (Pierce 3521)

(391) Under BCBSM practices, if a doctor performs services in a participating hospital, both the physician and the facility are paid a fee. However, since currently non-hospital freestanding surgical facilities are not possessed of participating status, they are not reimbursed for overhead costs. (Pierce 3525)

(392) Senator Pierce informed the Legislature that a cystoscopy is an operation where the bladder is looked at by going through the urethra with a specialized light; that under BCBSM, and under Medicare and Medicaid, if the patient is admitted for a one-day stay in a hospital, which frequently happens, the costs can be in the range of $700; if it is done in a hospital out-patient surgical suite, the cost is usually around $400; and if it is done in the physician's office or in physician-owned outpatient facility, the cost is usually in the range of $100. (Pierce 3526)

(393) Senator Pierce requested an opinion concerning free-standing facilities from Elliot Wicks, an employee of the Office of Health and Medical Affairs. Wicks is recognized as an expert in the field of health care economics. (Feldstein 2205; Pierce 3563) Wicks responded in writing on May 9, 1980, indicating in part:

> "You questioned the fairness of reimbursing hospital-related clinics but not clinics operated by individuals. I would agree with the implication of the question that, other things being equal, it would be best to treat the two types of institutions the same way. (deletion) Incidentally, I have a very hard time understanding the application of the concept of equity as applied to *institutions*. It seems to me that there is no moral obligation to strive to be equitable to institutions but only to *individuals*. (deletion) . . . it is the individuals who should be the object of concern when we speak of fair treatment."
>
> "You suggest that free-standing surgical clinics could provide competition and help bring down prices, and that we could control proliferation if we paid for out-patient services on a per unit basis. I don't find this persuasive because I don't think competition will have the desired effect. First, reimbursers typically reimburse for such services for *costs* of providing the service. If there is excess capacity in the system and as a result, costs are higher than they would be in a smaller system operating at a full capacity, the reimbursers will be covering all costs and thus paying more than if the system were smaller . . . . Second, I fear that the existence of too many clinics with excess capacity may result not in competition in terms of price (which neither consumers nor providers have much reason to be concerned about if the procedure is insured) but rather the competition will be for physicians to treat their patients in a particular unit. To make the unit attractive to physicians and patients, they will add amenities and escalate costs. Further, physicians may generate unnecessary surgery when there is a great deal of

L. New providers—new benefits

(1) State institution reimbursement

(358) During the period October 1, 1977, through September 30, 1979, approximately 17.5 percent of the persons admitted to state-owned psychiatric hospitals were eligible for BCBSM benefits. (Winter 1941; Def Ex. 16 p 1941) No evidence was presented indicating that a lesser percentage exists today.

(359) BCBSM treats state-owned psychiatric hospitals as nonparticipating facilities with reimbursement levels being at the same level BCBSM pays other nonparticipating facilites. (Udow 230)

(360) No state-owned health care facility is treated as a participating provider. (Udow 230-231)

(361) At the present time there are no privately-owned psychiatric hospitals that are not participating with BCBSM. (Udow 263)

(362) BCBSM's concern with impact of PA 350 relates to state-owned psychiatric institutions. (Udow 231)

(363) At the present time, BCBSM is paying a nonparticipating fee of $15 per day for persons in these state-owned psychiatric facilities. Payments by BCBSM are not made to the State but rather to the individual or individual subscriber. The State bills the subscriber or the family. (Udow 233, 259)

(364) If a person meets the statutory standards for payment for mental health care, the person is billed by the State. (Winter 1863)

(365) Charges vary at the state-owned psychiatric hospitals, $102 to $282 per day. (Winter 1866-1867)

(366) In 1981, there was in excess of 650,000 acute patient days in state-owned psychiatric hospitals. BCBSM insured patients were involved with 18 to 20 percent of those days. (Winter 1869)

(367) In 1981, the inpatient days cost the State of Michigan $183,397,858. It recovered from others as follows:

Medicaid	$15,431,000
Medicare	8,934,000
Commercial insurers	7,525,000
Patients/families	4,991,000
BCBSM	1,042,500
	$37,923,500

(Winter 1870-1872)

(368) BCBSM's stated reasons for not participating with state-owned psychiatric hospitals are:

a. State psychiatric hospitals are operated by the State of Michigan to serve a distinct public and are supported by general tax dollars;

b. State psychiatric hospitals are not licensed;

c. State psychiatric hospitals are not subject to need planning restraints;

d. BCBSM has more than enough private acute care beds to serve the needs of its subscribers;

e. Occupancy rates at private psychiatric hospitals range from 53-70%;

f. Participation would add substantial expense to BCBSM;

g. Cost accounting methods are inadequate to satisfy BCBSM standards;

h. State psychiatric hospitals have no or inadequate provisions for peer review;

i. State psychiatric hospitals do not have community governing boards.

(Def Ex. 16, p 72-85)

(369) State psychiatric hospitals are not licensed by any governmental agency. (Winter 1926)

(370) BCBSM's stance has consistently been that it will not participate with unlicensed facilities. (Winter 1959-1960)

such coverage does not work well; substance abuse services have to be rendered and are less expensively rendered in settings which are other than hospitals, such as in outpatient settings; and that substance abuse services must be available because worker productivity is affected by substance abuse. (Brown 3672-3673)

(404) Representative Mary Brown argued to her fellow legislators in favor of mandatory substance abuse coverage saying that substance abuse treatment in freestanding facilities and other non-hospital facilities had been cost effective; that such a program existed in her area, and it was cost effective; and BCBSM and the commercial carriers should be treated equally on this issue. (Brown 3672-3673)

(405) A spokesperson for Chrysler Corporation testified before the House Insurance Committee on November 5, 1979, objection was voiced to any bill which requires Chrysler to provide any specific benefit to its employees. (Pls Ex. 48, p 5)

(406) Ford Motor Company informed the Legislature that "We believe companies should have the right to purchase benefits they decide to offer to employees (whether through collective bargaining or otherwise)." (Pls Ex. 56, p 2)

(407) Mandated benefits in the substance abuse area will cost BCBSM and its subscribers 1.84 million dollars in the first year and 7.93 million dollars in the first three years. (Udow 244-245)

(408) No evidence was tendered that would dilute or contradict the conclusion of the drafters of the State Health Plans that there are substantial numbers of people who do not take advantage of substance abuse services because of the costs involved; and further that treatment is more difficult and more costly when not rendered in the early stages of substance abuse.

M. Regulatory/administrative costs

(409) A "provider class plan" is a document which must be generated under PA 350 for each provider class, encompassing reimbursement arrangements and contracts with provider classes. (Benner 771)

(410) Section 505 of PA 350 requires consultation with providers, subscribers, and other interested persons in the development of provider class plans. There are 13,000 physicians in the State of Michigan. BCBSM covers nearly 5 million people in the State of Michigan. There are approximately 9.5 million people in the State of Michigan. Section 505 offers no guidance with respect to how many of these nearly 10 million people BCBSM would have to consult with in the development of provider class plans. (Benner 771-772)

(411) When BCBSM instituted a foot surgery predetermination program designed to limit the utilization of elective foot surgery, the podiatrists sued BCBSM alleging, among other things:

"a. That the program violates Section 501(1) of PA 350 because BCBSM did not consult with all podiatrists prior to instituting the program, and

b. That the program violates Section 505(2) of PA 350 because BCBSM did not establish a procedure for permitting advice and consultation of podiatrists prior to institution of the program."

(Udow 247-248; Pls Ex. 19 46, 48)

(412) The development, filing, and monitoring of the operation of provider class plans will conservatively cost BCBSM and its subscribers 1.5 million dollars each year. (Bush 941-944)

(413) A "contested case" is essentially similar to civil litigation, with discovery and a full trial on the merits. In the most recent BCBSM contested case, over 500 interrogatories were submitted to BCBSM by the Insurance Bureau Staff and five intervening parties. (Benner 773)

(414) Responding to discovery requests in the most recent contested case entailed over 1,200 man hours. (Benner 814)

unused capacity available. In short, I fear that demand may expand to meet supply (though I agree there are limits on the extent to which this will happen)."

(394) It is less than conclusive that mandatory participation under Section 402(8) with non-hospital freestanding surgical facilities will result in an estimated increase in BCBSM's total payments of $753,000 in the first year and 10 million dollars over a five-year period. (Udow 239)

L. (3) Substance abuse

(395) Arguments over substance abuse occurred in relation to separate amendatory language after PA 350 was passed. (Pierce 3527)

(396) Currently, substance abuse coverage is optional and only about one-half of BCBSM subscribers have opted for that coverage. (Udow 242)

(397) For the most part, it is only the automobile companies which have purchased substance abuse coverage. (Udow 310)

(398) Both the State Health Plan for 1979-1983 and the State Health Plan for 1980-1984 recommended that the Legislature consider legislation that would require all group health insurance policies offer coverage for substance abuse related health problems. Both Plans read:

"THE LEGISLATURE SHOULD MANDATE THAT ALL GROUP HEALTH INSURANCE POLICIES OFFER COVERAGE FOR SUBSTANCE ABUSE RELATED HEALTH PROBLEMS."

"The Department of Health, Education, and Welfare, the American Medical Association, the American Psychiatric Association, and the World Health Organization consider substance abuse, specifically alcoholism, to be a disease."

"There are substantial numbers of people who do not take advantage of substance abuse services because of the costs involved. Further, of those who do receive such

services, many receive services only in the later stages of the problem when treatment is both more difficult and more costly."

"Since substance abuse is a factor in some other diseases, reduction of the substance abuse problem should result in overall health improvement."

(Def Ex. 33, p 298; Def Ex. 35, p 370-371)

(399) The State Health Plan for 1980-1984, in relation to pre-natal and well-baby care, states:

"An alternative that was considered was having the legislature mandate that preventive services be a covered service under all comprehensive plans. This alternative was rejected because of the view that it would be an interference with the process of determining benefits through labor/management negotiation and would limit the right to determine such matters by contract."

(Def Ex. 35, p 618)

(400) The Legislature passed other legislation relating to substance coverage by commercial carriers. (Pierce 3528)

(401) The Health and Social Services Committee, chaired by Senator Pierce, heard arguments and statements made by recovered alcoholics, drug addicts, and witnesses from the Office of Substance Abuse. (Pierce 3528-3529)

(402) Recovered alcoholics testified in front of the Health and Social Services Committee to the effect that the essential problem with obtaining substance abuse services, especially as an outpatient was that in many cases the individual alcoholic or drug addict would not pay, or could not pay, for outpatient substance abuse services, and that because of lack of services, the alcoholic would continue to drink and would eventually end up needing more expensive hospital care. (Pierce 3528-3529)

(403) Arguments were made that *allowing* the selection of coverage for substance abuse services rather than *requiring*

(415) In the most recent contested case, a rate request filing was made on September 21, 1981. Discovery lasted until May 15, 1982, when the actual trial began. The trial lasted 28 days. (Benner 774)

(416) The most recent contested case has cost BCBSM over $200,000 exclusive of any appeals which may follow. This figure is representative of the costs of contested cases concerning the individual lines of coverage that were involved. (Benner 774-775)

(417) Review of the rates for the individual lines of coverage is required every year, and it is likely that a contested case hearing will be required whenever a rate increase is sought on those lines. (Benner 776-777)

(418) In the past there has been no provision for contested cases concerning subscriber complaints or provider class plans. (Benner 776)

(419) Under PA 350, five provider class plans will be reviewed each year. (Benner 777-778)

(420) It is BCBSM's understanding that under PA 350, any provider, subscriber, or other affected person can request a contested case hearing on the review of provider class plans.

(421) Because of the importance of the issues which would be involved in the review of a provider class plan, it is anticipated that every plan review will result in a contested case. (Benner 778-779)

(422) It is anticipated that the costs of contested cases concerning provider class plan reviews will be substantially similar to contested case hearings on rate request filings. (Benner 779-780)

(423) Contested cases concerning provider class plan reviews could cost BCBSM up to 1 million dollars each year.

(424) BCBSM processes approximately 55,000,000 claims for services rendered each year. (Benner 782; Def Ex. 3, p 6)

(425) BCBSM handles roughly 2.6 million customer inquiries each year. (Def Ex. 3, p 9)

(426) Approximately eighteen million of the 55,000,000 claims for payment each year are received from physicians. Based upon experience with the Medicare complaint system, BCBSM expects to receive 240,000 written complaints which will ultimately result in 1,300 potential contested cases or matters that would go to the Insurance Bureau. (Benner 782-783, 819, 821)

(427) On the hospital claims side, based again upon Medicare experience, BCBSM expects to receive approximately 500 written complaints each year, about 350 of which could go to contested cases. (Benner 783-784)

(428) There are approximately 22 million more claims that arise by way of vision, dental, hearing, and master medical activities of BCBSM. There exists no means of estimating the number of contested cases that may result from these areas of operation. (Benner 786-787)

(429) The cost to BCBSM of handling the physician and hospital contested cases on subscriber complaints, based on the Medicare complaint system, will be approximately $440,000 each year. (Benner 784-785)

(430) In the past, BCBSM has relied on the government and professional organizations to assure quality health care in the State of Michigan. (Bush 939-940)

(431) Having to hire qualified personnel to monitor quality for BCBSM, assuming this is possible, will cost BCBSM approximately 1.5 million dollars each year. (Bush 937-938, 940)

(432) A representative of Chrysler Corporation addressed the Legislature on the issue of administrative burden as follows:

> "H.B. 4555 . . . is designed to apply to but one of many competitors, Blue Cross and Blue Shield of Michigan. It

clearly imposes administrative hurdles and, more importantly, administrative costs on only one competitor. This is not only unfair, but since Blue Cross and Blue Shield of Michigan is Chrysler's largest carrier . . . this Bill, in its present form, can only lead to higher health care costs for Chrysler. . . ."

(Pls Ex. 48, Maher attachment, p 1)

(433) PA 350 will greatly increase the administrative and regulatory costs of BCBSM.

N. Per case participation

(434) A formally "participating physician" is one who executes an agreement with BCBSM whereby the physician agrees to accept the BCBSM payment as payment in full for services rendered to BCBSM subscribers. (Hall 324)

(435) A formal participation contract can be cancelled on 15 days notice. (Hall 324)

(436) In 1981, BCBSM received approximately 55 percent of all physician claims from formally participating physicians. (Hall 328)

(437) In 1980, of the 10,090 medical doctors in Michigan, 6,813 (67.5%) were formally participating physicians. Of the 2,291 osteopaths, 2,043 (89.2%) were formally participating physicians. Of the 434 podiatrists, 412 (94.9%) were participating with BCBSM, as were 762 of the 966 chiropractors (78.9%). (Def Ex. 4, p 10)

(438) The 1981 formally participating figures were substantially the same as those for 1980. (Def Ex. 3, p 10)

(439) A nonparticipating physician can participate on a per case basis in which event he or she submits a "pay provider" claim form and by doing so, agrees to accept the BCBSM payment as payment in full for the service billed. This is referred to as "per case participation." (Hall 324-325)

(440) In 1981, approximately 42 percent of the total physicians' claims came from nonparticipating physicians with a "pay provider" direction indicated. (Hall 329)

(441) A nonparticipating provider may also submit claims as "pay subscriber signed" and "pay subscriber unsigned." Where a claim is submitted as "pay subscriber unsigned," it means there is no prior agreement between the patient and the physician as to recognition by the patient for any liability over and above the BCBSM payment. When a claim form is submitted as "pay subscriber signed," the patient's signature on the claim form acknowledges that there may be a subscriber liability to the physician for the difference between what BCBSM pays and what the physician bills. (Hall 325)

(442) In 1981, 1.7 percent of physician claims to BCBSM were submitted "pay subscriber unsigned." (Hall 330)

(443) In 1981, so far as BCBSM is aware, 98.7 percent of all physician's claims were submitted without subscriber liability. (Hall 330)

(444) Currently, physicians can participate on a per case basis for a given procedure at one point during the calendar year and then not participate on that procedure at other times in that same calendar year. (Hall 326)

(445) Section 502(1)(b) provides for per case participation but requires that the provider agree to "accept payment from the [health care] corporation as payment in full *for all cases involving the procedure specified, for the duration of the calendar year.*"* The witness, John Bryan, M.D., testified: ". . . if in January of a given year I accept per case participation, that means that for that service the rest of the year I am locked into having to accept that same benefit." (Bryan 196)

* Underlining supplied.

(446) Nonparticipating physicians desire the freedom to select those cases in which they chose to participate on a per case basis depending upon the subscriber's ability to pay. (Bryan 195-196)

(447) Maximum screens fix or set forth the most BCBSM will pay for any given procedure and are kept confidential so that all physicians do not charge up to that amount. (Hall 336)

(448) Maximum screen adjustments can occur any time during a calendar year. (Hall 337)

(449) Maximum screens are lowered on occasion by BCBSM. (Hall 334; Bush 931)

(450) If screens are lowered enough and BCBSM does not reimburse physicians enough for a given procedure, physicians simply refuse to participate. (Bryan 193-194; Powsner 3189; Hall 342)

(451) There will be reluctance on the part of physicians to lock themselves into participation on a given procedure for the duration of the calendar year when the BCBSM payment for that procedure may be lowered thereafter. (Hall 331-334, 391-392; Bryan 196-197, 225)

(452) The impact of Section 502(1)(b) will be to reduce the number of claims submitted by nonparticipating providers on a per case basis, i.e. pay provider claims will decrease. This decrease will range between 12½ to 25 percent. (Hall 331; Bryan 196-197; Feldstein 2154; Asmussen 1336)

(453) Where BCBSM is a small part of their market, and where they don't worry about competitors, some physicians may cease participating on a per case basis because of Section 520(1)(b). For other physicians, Section 502(1)(b) will bring about participation and in turn lower prices. (Feldstein 2154-2155)

(454) Section 502(1)(b) will not greatly harm BCBSM or its subscribers.

O. Section 205
Contingency reserves and lines of business

Note: Believing that it may be of assistance in understanding the various findings of fact which follow in relation to Section 205 of PA 350, the Court here sets forth certain

conclusions extracted from the testimony of the witness Steven Henry.

Section 205 may be broken into five different areas. Subsection (1) gives the Commissioner disapproval power over the creation of any new liabilities which are properly includable in the contingency reserves and gives the Commissioner disapproval power over assets or liabilities which are not established at reasonable values and in accordance with sound actuarial practices for generally acceptable accounting principles.

The second area would be subsections (2) through (8) which establish an initial contingency reserve of 11.5 percent and designate a methodology whereby that level of contingency reserve is modified for changes in the distribution of business of the corporation.

The third area would be subsections (9) through (12) which establish a corridor for contingency reserves which, if the corporation falls outside of that range, would trigger some action by either the corporation or Commissioner. Also established is a contingency reserve contribution to be triggered if the contingency reserves are within certain ranges.

The next area would be subsections (13) and (14) which are definitions used in the section.

The fifth area is subsection (15) which relates to the mechnism for splitting the cost of the panel of actuaries.

The methodology employed to modify the level of contingency reserves according to the distribution of business outlined in Section 205(2) through (8) is as follows: The legislation establishes in subsection (2) an initial contingency reserve "in the form and amount determined by the commissioner, *or* 11.5% of the previous year's total incurred claims and incurred expenses, whichever is greater." Risk factors are assigned by type of business. Those risk factors are then used to compute a weighted risk factor for the business as a whole, using as a starting point the distribution of business as of 1979. That weighted risk factor is then divided into 11.5 percent. The resulting figure is known as the "adjustment factor." When the adjustment factor is multiplied by the various risk

factors and by the distribution of business, it will return an 11.5 percent contingency reserve requirement when using the distribution of business as of 1979. In subsequent years, if the distribution of business changes to a type of business which has less risk, such as an administrative services contract, then, although the same adjustment factor and the same risk factors may be used, the calculation will produce a smaller contingency reserve target.

What the adjustment factor does is to force the weighted risk factor to an 11.5 percent level when you use the 1979 distribution of business. (Henry 2964-2966)

(455) It is important to persons covered by BCBSM that an adequate level of contingency reserve is maintained since money has been paid with the anticipation that the bargain on the part of BCBSM will be fulfilled. (Houghton 1140)

(456) There are a number of advantages to the community in having a Blue plan since it is liberal in underwriting risks, and it usually offers coverage to senior citizens at the lowest rates. (Houghton 1167-1168)

(457) In determining an adequate contingency reserve, each situation must be analyzed on its own particular facts. (Houghton 1142)

(458) In 1977, the witness Houghton, after a study conducted for the Michigan Insurance Bureau, concluded that an adequate contingency reserve for BCBSM would be 12½ percent. Upon further and later consideration, he concluded that an 11.5 percent contingency reserve was appropriate. (Houghton 1145-1146)

(459) In determining risk factors and an adequate contingency reserve, there is room for substantial differences of opinion between actuaries viewing the same problems. (Houghton 1153)

(460) Past experience should be taken into consideration in establishing an adequate contingency reserve. (Houghton 1152)

(461) Interest earnings from contingency reserves could be used to reduce the premiums of subscribers. (Houghton 1162-1163)

(462) Determination of appropriate risk factors directly affects the Company's ability to provide health care coverage in terms of establishing adequate premium charges and an adequate contingency reserve. (Houghton 1158)

(463) Defining contingency reserve, as in PA 350, as a percentage of incurred claims and expenses for the previous calendar year creates a risk of understating or overstating the adequacy of reserves if there develop dramatic changes in the make-up of the subscriber base. (Houghton 1147-1148)

(464) The factors that affect determination of an adequate and appropriate contingency reserve are dynamic and can change over a short period of time. (Houghton 1147)

(465) Newly mandated benefits could affect the adequacy of the contingency reserve. (Houghton 1154-1155)

(466) Delays in rate approvals have an adverse impact on the level of contingency reserves. (Houghton 1164-1165)

(467) It is possible that the allowances for temporary contributions to contingency reserves, as provided for in Section 205, may not be large enough to restore adequate reserves once depleted to a low level. (Houghton 1291, 1293-1294)

(468) There have been changes in the healthcare business since 1979, and from a sound actuarial practice standpoint, one would not want to limit his consideration to the distribution of business as of December 31, 1979. The distribution of business in 1980 and 1981 would be relevant in any actuarial determination. (Houghton 1157-1158)

(469) As used in the experience rating system, "credibility" is an attempt to measure the amount of trust or belief that the corporation and the Insurance Bureau wishes to place in a group's own claim experience when attempting to use that claim experience to project or anticipate future claims. The

smaller group is considered less credible or trustworthy than the larger group. Therefore, as a group increases in size, the credibility factor increases. Under the current system, a group size of 1,000 subscribers has full credibility, or a credibility factor of one. That factor reduces downward as the group becomes smaller. (Henry 2952-2953)

(470) For groups of under 1,000 subscribers, the experience is determined by pooling the experience of all non-fully credible groups. (T 2953)

(471) Currently, in rate filings done under the experience rating system, the methodology for determining the contingency reserve factor is a component of the experience rating system. That methodology is approved by the Insurance Bureau. (Henry 2950)

(472) Risk factors are a component of the experience rating system and are reviewed and approved by the Insurance Bureau. (Henry 2950)

(473) Under merit rating, the contingency reserve factor and the risk factor were components of the base rate filing and were reviewed and approved by the Insurance Bureau. (Henry 2955)

(474) Under the merit rating system, the specific level of the contingency reserve factor were reviewed and approved by the Insurance Bureau for use during the next year in the operation of the merit rating system. (Henry 2955-2956)

(475) Under the merit rating system, in the process of approval of the base rates, all components or factors of those base rates were reviewed for approval by the Insurance Bureau. That includes such things as the paid claims, the ratio of obligations to charges, incurring factors, trend factors, the conversion subsidies, the contingency reserve factors, risk factors, and administrative expense factors. (Henry 2956)

(476) By virtue of a negotiated settlement reached last year, the area rated groups changed from the merit rating system to a community rating system. (Henry 2957)

(477) Under the current system, if BCBSM were to make a rate filing, factors such as the contingency reserve factor, the risk factor, incurring factors, and trend factors, would be reviewed as part of the filing and action would be taken by the Insurance Bureau on those factors. (Henry 2958)

(478) In reviewing a filing for the individual lines of business, the Insurance Bureau reviews and approves a contingency reserve factor, if any, a risk factor, if any, and trend factors, among other things. (Henry 2959)

(479) The review of BCBSM base rate filings, formula filings, and form filings, by the Insurance Bureau has not changed as a result of the consolidation of Blue Cross and Blue Shield. (Henry 2959)

(480) While the witness Houghton testified that the method of determining the target contingency reserve as set forth in Section 205 is too inflexible to account for major changes in the market, the witness Henry testified that Section 205 is workable. (Houghton 1292-1293; Henry 2969, 2981) The testimony that Section 205 is too inflexible is not persuasive. Neither is the Court persuaded that the allowances for temporary contributions to contingency reserves will not be large enough to restore adequate reserves once depleted to a low level.

(481) Section 205(4) of PA 350 reads in part: "A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business." Section 205(5) reads in part: ". . . the Commissioner shall . . . (b) Define 1 or more additional lines of business . . . . "

(482) The phrase "line of business" is not defined in Section 205, and no standards are set forth in the Section which could guide the Insurance Commissioner's discretion in defining "lines of business." (Henry 2987-2988)

(483) Steven Henry, employed by the Michigan Insurance Bureau since 1970 and an individual with an actuarial back-

ground, concluded that the term "line of business" refers to rating categories such as ASC's, formula one, formula two, area group, non-group, and group conversion. (Henry 2994-2995)

(484) The phrase or term "line of business" is used in the heading or title of certain columns in the Annual Statement of BCBSM for the year of 1981. Thereafter followed the words "Hospital," "medical," "Dental," and "Other." BCBSM responded by inserting approximate figures. (Def Ex. 1, "Underwriting and Investment Exhibit," Part 1 and Part 2)

P. Part 5

(485) Section 504(1) of PA 350 reads in part as follows:

> "A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:
>
> > (a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.
> >
> > (b) Providers will meet and abide by reasonable standards of health care quality.
> >
> > (c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

(486) The State Health Plan assumes that there is a role for state government in assuring each of the three goals of reasonable access, reasonable cost, and quality, and that without a long-term policy framework, it will not be possible to achieve an appropriate balance between the three goals. (Rosen 2692)

(487) The three "goals" of Part 5, "access," "quality," and "reasonable cost" are conflicting with one another. (Rosen 2543, 2669)

(488) The State Health Plan is a collection of proposals to provide health care services, to achieve reasonable access and quality at a reasonable price. (Rosen 2548)

(489) BCBSM has traditionally relied on state agencies and professional organizations to assure the "quality" of health care in this State. (Bush 1051; Asmussen 1368)

(490) There is a consensus that the quality of care rendered by providers in Michigan is adequate. Michigan has a complex regulatory system designed to assure quality. (Rosen 2666-2667)

(491) Quality assurance does require constant attention. (2667-2668)

(492) The Statewide Health Coordinating Council took the position before the Legislature that the State has the primary role in assuring quality of care, accessibility of care, and cost containment. (Def Ex. 42, p C1)

(493) The federal government has taken the position that "the achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government." (Def Ex. 33, p 3; Def Ex. 35, p 3)

(494) Cost, access, and quality are inextricably related. One can only alter the degree to which you pursue one of those three if you are prepared to alter the other two.

(495) The Shelton Coalition, which was responsible for developing much of Part 5 of PA 350, was never able to figure out a way to quantify or measure the "quality" goal. (Shelton 2582-2583)

(496) The State Health Plans seek to promote "quality" health care, but they define "quality" as: "A measure of the degree to which health services delivered to a patient meet standards of acceptable professional judgment, conduct, and outcome." (Rosen 2688)

those services. Providers benefit from increased utilization. (Rosen 2712)

(517) BCBSM uses a system which is a variety of the fee-for-service approach. (Rosen 2712-2713)

(518) The key components in determining health care costs consist of:

1. Cost of hospital and related services,
2. Physicians' charges,
3. Administrative expenses,
4. Reserves accumulation, and
5. Utilization.

(Manzo 1805-1806)

(519) BCBSM could take measures to provide reasonable health care costs. Some of the measures that could be taken include: (1) the insisting upon second-opinion surgery (one study indicated that something like one-third of the second opinions did not indicate surgical procedure was necessary). (Feldstein 2216); (2) the utilization of the preferred provider approach under which it would contract with providers to provide services at a price that is acceptable. (Shelton 2895)

(520) Jack Shelton, who is the Chairman of the Health Care Cost Containment Coalition, and who was also the former Chairman of the Health Care Cost Committee of BCBSM, believes that the cost containment provisions of Part 5 of PA 350 will work and will have a substantial effect on health care costs in Michigan. (Shelton 2589)

(521) Defense Exhibit 54 was prepared at the direction of Jack Shelton, and on behalf of Ford Motor Company, on or about August 14, 1979, made public.

(522) If over the four years preceding August 14, 1979, the rate of increase in health care costs had been consistent with real growth in the economy plus inflation as provided for in PA 350, BCBSM's physician and hospital costs would have been approximately $137 million less—a savings of 8 percent. (Def Ex. 54)

(523) BCBSM currently enjoys both hospital and physician "differentials"—sometimes called "discounts."

(524) The fact that BCBSM enjoys the hospital differential, standing alone, does not mean that BCBSM has an unfair competitive advantage over commercial insurance companies. (Kauper 3820-3821)

(525) The hospital differential is justified in part due to less administrative expenses and less bad debt in dealing with BCBSM subscribers. It is also justified in part by the fact that the Blue plans extend coverage to segments of society that commercial insurance companies do not wish to underwrite. (Manzo 1849-1851)

(526) Unfairness to commercial insurance companies, the people who pay the commercial insurers' rates, and the segment of society without prepaid health care coverage arises if the provider involved raises charges to others in order to recoup some or all of the differential awarded to BCBSM. This process of recovering from another is termed "shifting."

(527) Sections 509(4) and 516(2)(b) address the matter of shifting.

(528) The 27 percent hospital differential which existed in New Jersey prior to 1978 legislation presented a problem to hospitals. Hospitals made up the discount that they were giving to the Blue Cross subscribers by raising prices to the commercial insurers. While this was possible to do in suburban hospitals, it was not possible in inner-city hospitals, and a number of inner-city hospitals were moving into bankruptcy. (Manzo 1733)

(529) In 1978, the New Jersey Legislature reduced Blue Cross' hospital differential from 27 percent to a statutory level of 6 percent. The justification argued for keeping the differential was twofold: one, that Blue Cross provided certain benefits to institutions, such as computerized billing; and two, that Blue Cross provides health care coverage to people at less than self-supporting rates. (Manzo 1731-1733)

(530) Blue Cross of New Jersey has not lost business because of the reduction in hospital differential. (Manzo 1735)

(531) Sections 509(4)(b) and 516(2)(b) were proposed by the Shelton Coalition, and are in almost the exact words of the Shelton Coalition. (Shelton 2590-2591)

(532) The Shelton Coalition did not want any shifting. (Shelton 2928)

(533) No persuasive evidence was presented demonstrating that BCBSM is currently paying to any provider less than its fair share or that any portion of BCBSM's fair share of reasonable costs are being borne by other health care purchasers. Neither was persuasive evidence produced indicating that any portion of BCBSM's fair share of hospitals' reasonable financial requirements are being borne by other health care purchasers. (The witness Feldstein testified that these two Sections would have no impact upon BCBSM since it is paying its share of hospital and physicians' charges. (2157-2158))

(534) Certain provisions of PA 350 are in conflict with the goals of Part 5:

1. Provisions which drive up BCBSM administrative and regulatory costs; and
2. Provisions which mandate new benefits and new provider types.

(535) BCBSM will have a very difficult time meeting the cost goal. (Bush 1024, 1046)

Q. Miscellaneous

(536) The Michigan Association of Administrative Law Judges (MAALJ) is a group of hearing officers and administrative law judges who work for various departments of the State of Michigan. (Tavoularis 758-759)

(537) A person must have five years experience as a practicing attorney to gain a civil service position as a hearing officer or administrative law judge. (Tavoularis 759-760)

(538) MAALJ members are assigned cases on the blind-draw system, and their pay is in no way dependent upon the decisions they reach. (Tavoularis 762)

(539) Section 503 of PA 350 reads:

> "In the course of developing and establishing provider class plans under this part, a health care corporation shall address the issue of uniform reporting by health care providers."

(540) Regarding Part 5, Jack Shelton, Chairman of the Michigan Health Care Cost Containment Coalition, on April 25, 1980, forwarded a draft of Part 5 dealing with provider contracts and reimbursement. He indicated to members of the Legislature that the draft of proposed legislation was the result of discussions held over the last ten months with consumer, provider, business, and labor groups and representatives of the Michigan House and Senate. He indicated as well that the proposal had the support of the following:

> Chrysler Corporation
> Ford Motor Company
> General Motors Corporation
> AFL-CIO
> United Auto Workers
> BCBSM
> Michigan Hospital Association
> Michigan State Medical Society.
>
> (Def Ex. 48)

(541) The draft mentioned above contained the following language:

> "Sec. 504. In the course of developing and establishing provider class plans under this chapter, a corporation shall address the issue of uniform reporting by health care providers." (Def Ex. 48)

(542) Uniform reporting would facilitate the comparison of institution costs in a meaningful way and thereby be beneficial in cost containment. (Shelton 2921-2922)

(543) Cost reporting of providers to BCBSM is already on a uniform basis. However, accounting practices vary from hospital to hospital. (Hall 343-344, 346)

(544) The impact of Section 503 of PA 350 is impossible to assess because the phrase "uniform reporting" is subject to varying interpretations in the health care field. (Hall 343-345)

(545) The impact would be dramatic if it requires substantial alteration of provider accounting practices. (Hall 344)

(546) There are 14 organizations in the State of Michigan identified by the Insurance Bureau as nonprofit prepaid health care corporations, of which BCBSM is one. (Baerwaldt 3730-3731; Def Ex. 61, p. 9-10)

(547) PA 350 was directed at BCBSM. (Tuchinsky 2055; Shelton 2809; Brown 3683) (See also heading of Def Ex. 54 which reads "Goal Established in BC/BS Legislation")

(548) There have been 5 Commissioners of Insurance in the past 12 years, plus some acting Commissioners in between. (Henry 2985)

(549) Policies of the Insurance Bureau generally shift with a change of Commissioners. (Henry 2986)

(550) State Health Plans constitute planning documents. (Asmussen 1449)

(551) With respect to "community rating," (Section 611 of PA 350) the Statewide Health Coordinating Council took, in part, the following position before the Legislature:

> "We cannot support a mandate for community rating that applies only to BCBSM, since this would place the Blues at a competitive disadvantage in relation to other insurers."
>
> (Def Ex. 42, p C8)

(552) As to drafts submitted by the Shelton Coalition, the Coalition would provide suggestions to the Legislative Service Bureau, and the Bureau would then compose the drafts. (Shelton 2581)

(553) Joseph F. Johnston, Jr., partner in a New York law firm and editor of *Personal Liabilities of Corporate Officers and Directors*, addressed the Legislature on some of the problems created by these legislatively mandated procedures:

> "Under the present law, the directors of BCBSM, like the directors of any other profit or non-profit corporation, owe a duty of undivided loyalty to the corporation . . . including all subscribers . . . . He only has one interest to serve, and that the interest of the enterprise *as a whole*. By following the rule of undivided loyalty, every director seeks to preserve a financially sound and healthy corporation which will benefit *all* subscribers through providing efficient health care benefits at reasonable rates."
>
> * * *
>
> "Further, I would be concerned that the establishment by legislation of a legal fiduciary duty running directly to the subscribers would create a legal right of action by subscribers against each director individually. This would be a drastic change from the traditional rule that a member with a grievance can only sue the corporation, or, in some cases, can sue the directors, but only 'derivatively'—that is, in the name of and solely for the benefit of the corporation."
>
> * * *
>
> "I further believe that the built-in conflicts of interest inherent in this legislation and the increased risks of liability for the directors would make it more difficult to obtain directors' and officers' liability insurance. At a minimum, insurance would become more expensive."
>
> * * *
>
> "The proposed bill would establish an unusual and burdensome requirement that [certain actions] by the board, in order to be effective, must be by a majority of all directors elected. [See Section 303(4)]. This would mean, for example, that if a valid quorum of [18] directors attended the meeting, all 18 would have to vote in favor of [the] action to be taken. With a very large board such

(497) Quality of medical care is a very difficult thing to evaluate. (Pierce 3541)

(498) Because there is no meaningful way in which to measure or quantify "quality" health care, the "quality" goal cannot possibly serve as a meaningful balancing factor in determining whether the overall goals of Part 5 have been met. (Asmussen 1370-1371)

(499) The "access" goal of Part 5 is vague and subject to varying interpretations in the health care delivery system. (Bush 935-936)

(500) Before the Legislature, the SHCC took the position that it is the State which has the primary responsibility of assuring "access" to health care services. (Def Ex. 42, C1)

(501) The Shelton Coalition did not develop any standards by which the Insurance Commissioner might measure or determine "reasonable access."

(502) The State Health Plans seek "access" but acknowledge that there is no clear agreement on the indicators that would most adequately measure a genuine lack of access. (Rosen 2687)

(503) Except in utilizing its authority to guarantee loans (as provided for in Section 207(1)(i), no evidence was introduced as to how BCBSM could control the number and/or the distribution of physicians or other health care providers in the State of Michigan.

(504) As to "reasonable cost," the inability to measure or quantify "quality" and "access" in any meaningful way may cause the focus under Part 5 to be on the "cost" goal. (Asmussen 1344-1346)

(505) The State Health Plan for 1980-1984, which seeks to promote "access," "quality," and "reasonable cost," nevertheless states: "A major focal point of the evaluation effort will be the portion of the plan which deals with health care costs." (Def Ex. 35, p 30)

(506) Forcing changes in the reimbursement contracts with providers may result in loss of participation of some providers. (Asmussen 1349-1359)

(507) Achieving the Part 5 cost goals may result in BCBSM breaching its participating contracts with hospitals. (Asmussen 1446-1447)

(508) Part 5 of PA 350 does not require provider participation with BCBSM nor does it subject providers to the cost goal. (Asmussen 1350)

(509) BCBSM does not have control over many of the factors which affect health care costs in this State. (Asmussen 1354)

(510) A requirement to any successful BCBSM cost containment effort is provider participation. (Asmussen 1328)

(511) BCBSM cannot guarantee "access" or "reasonable cost" if providers refuse to participate.

(512) To effectively address the issue of cost containment (and in turn "reasonable cost" to subscribers) all of the factors in the system and all of the factors which affect health care costs must be addressed. (Asmussen 1354-1357, 1419-1421; Manzo 1806-1808; Feldstein 2217-2219; Powsner 3187-3188; Rosen 2751)

(513) The inability to control utilization of services is the principal cause of the cost problem. (Rosen 2685)

(514) Blue Cross and Blue Shield of Michigan has the ability to, in part at least, reduce utilization. (Rosen 2698)

(515) The fee-for-service system is widely recognized as having perverse incentives in the sense that it rewards physicians for increased utilization and economically penalizes physicians for caring for patients in a way that minimizes the need for medical care. (Rosen 2713)

(516) Under fee-for-service arrangements, the more services are provided or consumed, the more is paid to the providers of

> as this one, there will always be some directors absent. If several directors happened to be absent, this unusual requirement would make it difficult in many cases to take any action at all."
>
> (Pls Ex. 52)

(554) No compelling state interest was advanced in support of restricting the speech rights of BCBSM officers, directors, and corporate members.

(555) By selling life insurance through American Bankers Life Assurance, a salesman already selling Blue Cross could imperil the operations of BCBSM if in fact the salesperson is a salaried employee of BCBSM whose time is paid for by the subscribers. (Brown 3697)

(556) A serious question exists as to how aggressive BCBSM should be in reducing its payments to hospitals. The SHCC took the position before the Legislature that:

> "The provision says that the Blues' policies should not result in other insurers paying more than their fair share. But if the Blues act aggressively in implementing cost containment policies, and if hospitals find it very difficult to cut costs sufficiently to meet the Blues' standards, the hospitals may well respond by increasing charges to patients who pay charges, so that these people would pay a disproportionate share. The question is, 'Is it possible for the Blues to institute policies to meet the cost containment goal without producing the result that this provision says is not to occur?' "
>
> (Def Ex. 42, p C4)

Respectfully submitted, this 1st day of November, 1982.

/s/ JACK W. WARREN

Jack W. Warren, *Circuit Judge*
Ingham County Circuit Court

Ingham County Circuit Court Supplement to Findings of Relevant Facts, November 9, 1982

STATE OF MICHIGAN
IN THE SUPREME COURT OF MICHIGAN

SC: 68903
LC: 81-26748

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, a non-profit Michigan corporation,

Plaintiff,

—vs—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, and COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

SUPPLEMENT TO RELEVANT FACTS

Comes now Jack W. Warren, Circuit Judge for Ingham County, and supplements the statement of relevant facts filed with this Court on November 1, 1982 as follows:

(557) Commercial insurance companies that offer health and medical coverage, of which there are 341 in the State of Michigan, are direct competitors of BCBSM. (Manzo 1801; Feldstein 2188; Baerwaldt 3274; Rosen 2750)

(558) Commercial insurance companies compete with BCBSM by skimming off the low-risk groups and leaving the more costly, high-risk groups with BCBSM. (Shelton 2923-2924; Houghton 1255; Manzo 1801-1802)

(559) Another manner in which commercial insurance companies compete with BCBSM is by being more flexible from customer to customer. (Shelton 2897-2898)

(560) BCBSM's so called "tax advantage" over commercial insurance companies amounts to approximately .2% to .3%. (Connell 3924-3925, 3978-3979; Pls Ex. 62)

(561) Due to out-of-pocket expenditures by people, and due to the private nature of physician records, it is not possible to ascertain *exactly* how much money is spent on health care in the State of Michigan. (Baerwaldt 3402; Rosen 2677)

(562) In both State Health Plans it is stated: "Currently data is not available which permits precise calculations of the percentage of per capita income spent in Michigan for health care services." (Def Ex. 33, p 481; Def Ex. 35, p 609)

Dated: November 5, 1982

_____

Jack W. Warren, *Circuit Judge*

Michigan Supreme Court Judgment,
April 16, 1985

AT A SESSION OF THE SUPREME COURT OF THE STATE OF MICHIGAN, Held at the Supreme Court Room, in the City of Lansing, on the 16th day of April in the year of our Lord one thousand nine hundred and eighty-five.

SC: 68903
CoA: 81-26748-CZ

Present the Honorable

G. MENNEN WILLIAMS,
Chief Justice

CHARLES L. LEVIN,
JAMES L. RYAN,
JAMES H. BRICKLEY,
MICHAEL F. CAVANAGH,
PATRICIA J. BOYLE,
DOROTHY COMSTOCK RILEY,
Associate Justices

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
non-profit Michigan corporation,

Plaintiff,

—v.—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

This cause having been brought to this Court by certification of questions at the request of the Governor and having been argued by counsel and due deliberation having been had thereon by the Court, IT IS HEREBY ORDERED AND ADJUDGED that 1980 PA 350 is constitutional except as to the following provisions which are adjudged to be unconstitutional in conformity with the opinion filed herein: Sec 205(6); Sections 104(3), 211, 414a, 415 and 607(1) insofar as they pertain to administrative services only contracts; and Sec 402(7), IT IS FURTHER ORDERED that this cause is REMANDED to the Circuit Court for the County of Ingham for dissolution of the injunction previously ordered by that court and further proceedings in conformity with the opinion filed herein.

Michigan Supreme Court Order Denying Motion for Rehearing, June 24, 1985

AT A SESSION OF THE SUPREME COURT OF THE STATE OF MICHIGAN, Held at the Supreme Court Room, in the City of Lansing, on the 24th day of June in the year of our Lord one thousand nine hundred and eighty-five.

SC: 68903
LC: 81-26748

Present the Honorable

G. MENNEN WILLIAMS,
Chief Justice

CHARLES L. LEVIN,
JAMES L. RYAN,
JAMES H. BRICKLEY,
MICHAEL F. CAVANAGH,
PATRICIA J. BOYLE,
DOROTHY COMSTOCK RILEY,
Associate Justices

Rehearing No. 146

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
a non-profit Michigan corporation,

Plaintiff,

—v.—

GOVERNOR OF THE STATE OF MICHIGAN, ATTORNEY GENERAL OF THE STATE OF MICHIGAN, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN,

Defendants.

On order of the Court, plaintiff's motion for rehearing, or in the alternative for a stay pending appeal to the United States Supreme Court, is considered and is hereby DENIED. The motion by the Michigan Association of Nurse Anesthetists for leave to file a brief *amicus curiae* is DENIED as moot.

Levin, J., would grant rehearing or grant a stay pending appeal to the United States Supreme Court.

Notice of Appeal, July 10, 1985

STATE OF MICHIGAN
IN THE SUPREME COURT

On Certification to the Supreme Court
from the Ingham County Circuit Court

Supreme Court No. 68903

Ingham Circuit Court No. 81-26748-CZ

BLUE CROSS AND BLUE SHIELD OF MICHIGAN,
a non-profit Michigan corporation,

Appellant,

—v.—

WILLIAM G. MILLIKEN, Governor of the State of Michigan, FRANK J. KELLEY, Attorney General of the State of Michigan, NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan,

Appellees.

NOTICE OF APPEAL TO THE SUPREME COURT
OF THE UNITED STATES

Notice is hereby given that appellant, Blue Cross and Blue Shield of Michigan, hereby appeals to the Supreme Court of the United States from the final judgment of this Court entered on April 16, 1985.

This appeal is taken pursuant to 28 U.S.C. § 1257(2).

Dated: July 10, 1985

/s/ STANLEY D. ROBINSON

Stanley D. Robinson

KAYE, SCHOLER, FIERMAN,
HAYS & HANDLER
425 Park Avenue
New York, New York 10022
(212) 407-8000

BUTZEL LONG GUST KLEIN
& VAN ZILE
1881 First National Building
Detroit, Michigan 48226
(313) 963-8142

Attorneys for Appellant

Michigan Nonprofit Health Care Corporation Reform Act, 1980 PA 350, MCL 550.1101 *et seq.*; MSA 24.660 (101) *et seq.*

NONPROFIT HEALTH CARE CORPORATION REFORM ACT

P.A.1980, No. 350, As Amended

AN ACT to provide for the incorporation of nonprofit health care corporations; to provide their rights, powers, and immunities; to prescribe the powers and duties of certain state officers relative to the exercise of those rights, powers, and immunities; to prescribe certain conditions for the transaction of business by those corporations in this state; to define the relationship of health care providers to nonprofit health care corporations and to specify their rights, powers, and immunities with respect thereto; to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance; to prescribe powers and duties of certain other state officers with respect to the regulation and supervision of nonprofit health care corporations; to regulate the merger or consolidation of certain corporations; to prescribe an expeditious and effective procedure for the maintenance and conduct of certain administrative appeals relative to provider class plans; to provide for certain administrative hearings relative to rates for health care benefits; to provide for certain causes of action; to prescribe penalties and to provide civil fines for violations of this act; and to repeal certain acts and parts of acts.

The People of the State of Michigan enact:

PART 1.

550.1101. Short title

Sec. 101. This act shall be known and may be cited as "the nonprofit health care corporation reform act".

550.1102. Purpose and intent

Sec. 102. (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

(3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

550.1103. Meaning of words and phrases

Sec. 103. For the purposes of this act, the words and phrases defined in sections 104 to 108 shall have the meanings ascribed to them in those sections.

550.1104. Definitions

Sec. 104. (1) "Administrative procedures act" means Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Michigan Compiled Laws, or a successor act.

(2) "Bargaining representative" means a representative designated or selected by a majority of employees for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment relative to the employees so represented.

(3) "Certificate" means a contract between a health care corporation and a subscriber or a group of subscribers under which health care benefits are provided to members, including a contract containing an administrative services only or cost-plus arrangement. A certificate includes any approved riders amending the contract.

(4) "Collective bargaining agreement" means an agreement entered into between the employer and the bargaining representative of its employees, and includes those agreements entered into on behalf of groups of employers with the bargaining representative of their employees pursuant to the national labor relations act, 29 U.S.C. 151 to 169, under Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws, or under Act No. 336 of the Public Acts of 1947, as amended, being sections 423.201 to 423.216 of the Michigan Compiled Laws.

(5) "Commissioner" means the commissioner of insurance. Commissioner includes an authorized designee of the commissioner, if written notice of the delegation of authority has been given as provided in section 601.

(6) "Contingency reserve" means the sum of all assets minus the sum of all liabilities of a health care corporation, as shown in the annual financial statement filed under section 602.

550.1105. Definitions

Sec. 105. (1) "Health care benefit" means the right under a certificate to have payment made by a health care corporation for a specified health care service, regardless of whether or not the payment is made pursuant to an administrative services only or cost-plus arrangement.

(2) "Health care corporation" means a nonprofit hospital service corporation, medical care corporation, or a consoli-

dated hospital service and medical care corporation incorporated or reincorporated under this act, or incorporated or consolidated under former Act No. 108 or 109 of the Public Acts of 1939.

(3) "Health care facility" means a facility or agency as defined in section 22104 of Act No. 368 of the Public Acts of 1978, being section 333.22104 of the Michigan Compiled Laws, and includes a home health agency, or other facility with the approval of the commissioner.

(4) "Health care provider" or "provider", except as provided in section 301(8)(a), means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; any other person or facility, with the approval of the commissioner, who or which meets the standards set by the health care corporation for all contracting providers; and, for purposes of section 414a, any person or facility who or which provides intermediate or outpatient care for substance abuse, as defined in section 414a.

(5) "Health care services" means services provided, ordered, or prescribed by a health care provider, including health and rehabilitative services and medical supplies, medical and rehabilitative services and medical supplies, medical prosthetics and devices, and medical services ancillary or incidental to the provision of those services.

550.1106. Definitions

Sec. 106. (1) "Large subscriber group" means a group of 10,000 or more subscribers.

(2) "Medium subscriber group" means a group of 150 or more subscribers, but less than 10,000 subscribers.

(3) "Member", except as used in parts 2 and 3, means a subscriber, a dependent of a subscriber, or any other individual entitled to receive health care benefits under a nongroup or group certificate.

(4) "Nongroup subscriber" means an individual subscriber who is not enrolled as a subscriber through any subscriber group.

(5) "Objectives" means an expected achievement level by a health care corporation of the goals provided in section 504, for a provider class. Insofar as is reasonably practicable, objectives shall be capable of quantitative measurement.

550.1107. Definitions

Sec. 107. (1) "Participating provider" means a provider that has entered into a participating contract with a health care corporation and that meets the standards set by the corporation for that class of providers.

(2) "Participating contract" means an agreement, contract, or other arrangement under which a provider agrees to accept the payment of the health care corporation as payment in full for health care services or parts of health care services covered under a certificate, as provided for in section 502(1).

(3) "Person" means an individual, corporation, partnership, organization, or association.

(4) "Personal data" means a document incorporating medical or surgical history, care, treatment, or service; or any similar record, including an automated or computer accessible record, relative to a member, which is maintained or stored by a health care corporation.

(5) "Proposed rate" means any of the following:

(a) A proposed increase or decrease in the rates to be charged to nongroup subscribers.

(b) For group subscribers, any proposed changes in the methodology or definitions of any rating system, formula, component, or factor subject to prior approval by the commissioner.

(c) A proposed increase or decrease in deductible amounts or coinsurance percentages.

(d) A proposed extension of benefits, additional benefits, or a reduction or limitation in benefits.

(e) A review pursuant to section 608(2).

(6) "Provider class" means classes of providers, as defined in section 105(4), that have a provider contract or a reimbursement arrangement with a health care corporation to render health care services to subscribers, as those classes are established by the corporation.

(7) "Provider class plan" or "plan" means a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract.

(8) "Provider contract" or "contract" means an agreement between a provider and a health care corporation that contains provisions to implement the provider class plan.

550.1108. Definitions

Sec. 108. (1) "Reimbursement arrangement" means policies, practices, and methods by which a health care corporation makes payments to a provider to implement the provider class plan.

(2) "Small subscriber group" means a group of less than 150 subscribers.

(3) "Subscriber" means an individual who contracts for health care benefits, either individually or through a group, with a health care corporation. Subscriber includes an individual whose contract contains an administrative services only or cost-plus arrangement authorized under section 207(1)(g).

PART 2.

550.1201. Formation of health care corporation; certificates, application of other laws

Sec. 201. (1) A health care corporation shall not be incorporated in this state except under this act.

(2) Not less than 7 persons, all of whom shall be residents of this state, may form a health care corporation under this act

for the purpose of providing 1 or more health care benefits at the expense of the corporation to persons or groups of persons who become subscribers to the plan, under certificates which will entitle each subscriber to certain health care services by providers with which the corporation has contracted for that purpose.

(3) A certificate shall not provide for the payment of cash or any other material benefit to a subscriber or the estate of a subscriber on account of death, illness, or injury except where payment is made to a subscriber for health care services by a provider who has not entered into a participating contract with the corporation or to reimburse a subscriber who has made, or is obligated to make, payment directly to a provider.

(4) A health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act. A health care corporation shall not be subject to the laws of this state with respect to corporations generally.

(5) A health care corporation subject to this act is declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

(6) A person shall not act as a health care corporation or issue a certificate except as authorized by and pursuant to a certificate of authority granted to the person by the commissioner pursuant to this act.

(7) A health care corporation shall provide only the kinds of health care benefits and certificates authorized by this act. A health care corporation shall not make or issue a certificate relative to health care benefits except as approved or otherwise authorized under this act.

550.1202. Articles of incorporation

Sec. 202. (1) Persons associating to form a health care corporation under this act shall subscribe to articles of incorporation that shall contain all of the following:

(a) The names and addresses of the incorporators.

(b) The location of the principal office of the corporation for the transaction of business in this state.

(c) The name by which the corporation shall be known and all assumed names under which the corporation does business. The corporate name shall not include the words insurance, casualty, surety, health and accident, mutual, or other words descriptive of the insurance or surety business, and shall not be so similar to the name of an insurance or surety company doing business in this or other states at the time of incorporation so as to tend, in the judgment of the commissioner, to create confusion in identity with that insurance or surety company.

(d) The purposes of the corporation, which shall be:

(i) To provide health care benefits.

(ii) To secure for all of the people of this state who apply for a certificate, the opportunity for access to coverage for health care services at a fair and reasonable price.

(iii) To assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services.

(iv) To achieve the goals of the corporation relative to access, quality, and cost of health care services, as prescribed in section 504.

(v) To offer supplemental coverage to all medicare enrollees as provided in section 411.

(vi) If under contract to serve as fiscal intermediary for the federal medicare program, to do all of the following:

(A) Carry out its contractual responsibilities efficiently, including the timely processing and payment of claims.

(B) Actively represent, in negotiations with the federal government and with providers of medical, hospital, and other health services for which benefits are provided under the federal medicare program, the interests of senior citizens as they relate to cost and quality of, and access to, health care services and administration of the program.

(vii) To engage in activity otherwise authorized by this act, within the purposes for which corporations may be organized under this act.

(e) The term of existence of the corporation, which may be in perpetuity.

(f) The time for the holding of the annual meeting of the corporation.

(g) Other terms and conditions not inconsistent with this act, necessary for the conduct of the affairs of the corporation.

(2) The articles shall be acknowledged by the persons signing them before a notary public. The notary public shall append his or her certificate of acknowledgment to the articles. The articles shall be in triplicate and upon proper forms as prescribed by the commissioner.

(3) Before the articles or amendments to the articles are effective for any purpose, they shall be submitted to the attorney general for examination. If the attorney general finds the articles or amendments to the articles to be in compliance with this act, the attorney general shall certify this finding to the commissioner. The articles or amendments shall be effective at the time certified by the attorney general.

(4) Each health care corporation shall pay a fee of $250.00 to the attorney general for the examination of its articles of incorporation, or $100.00 for the examination of amendments to the articles of incorporation. Each health care corporation shall pay a filing fee of $100.00 to the commissioner for filing its articles of incorporation or $50.00 for the filing of amendments to the articles of incorporation. The fees prescribed in this subsection shall be deposited in the state treasury and credited to the general fund of the state.

550.1203. Integration, restatement and amendment of articles of incorporation

Sec. 203. By action of its board of directors, a health care corporation may integrate into a single instrument the provisions of its articles of incorporation which are then in effect and operative, as theretofore amended. If the restated articles

restate and integrate and also further amend the articles, they shall also be adopted by the board of directors. Any amendment or restatement of the articles shall be subject to review, approval, or both, as provided in section 202(3) or 701, as applicable.

550.1204. Filing of statements and documents; examination by commissioner; certificate of authority

Sec. 204. (1) Before entering into contracts or securing applications of subscribers, the persons incorporating a health care corporation shall file all of the following in the office of the commissioner:

(a) Three copies of the articles of incorporation, with the certificate of the attorney general required under section 202(3) attached.

(b) A statement showing in full detail the plan upon which the corporation proposes to transact business.

(c) A copy of all certificates to be issued to subscribers.

(d) A copy of the financial statements of the corporation.

(e) Proposed advertising to be used in the solicitation of certificates for subscribers.

(f) A copy of the bylaws.

(g) A copy of all proposed contracts and reimbursement methods.

(2) The commissioner shall examine the statements and documents filed under subsection (1), may conduct any investigation which he or she considers necessary, may request additional oral and written information from the incorporators, and may examine under oath any persons interested in or connected with the proposed health care corporation. The commissioner shall ascertain whether all of the following conditions are met:

(a) The solicitation of certificates will not work a fraud upon the persons solicited by the corporation.

(b) The rates to be charged and the benefits to be provided are adequate, equitable, and not excessive, as defined in section 609.

(c) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of issuance of the certificate of authority, and is not less than $500,000.00 or a greater amount, if the commissioner considers it necessary.

(d) The amounts contributed as the working capital of the corporation are payable only out of amounts in excess of minimum required reserves of the corporation.

(e) Adequate and reasonable reserves are provided, as defined in section 205.

(3) If the commissioner finds that the conditions prescribed in subsection (2) are met, the commissioner shall do all of the following:

(a) Return to the incorporators 1 copy of the articles of incorporation, certified for filing with the chief officer of the department of commerce or of any other agency or department authorized by law to administer Act No. 284 of the Public Acts of 1972, as amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws, or his or her designated representative, and 1 copy of the articles of incorporation certified for the records of the corporation itself.

(b) Retain 1 copy of the articles of incorporation for the commissioner's office files.

(c) Deliver to the corporation a certificate of authority to commence business and to issue certificates which have been approved by the commissioner, or which are exempted from prior approval pursuant to section 607(2) or (7), entitling subscribers to certain health care benefits.

550.1205. Recording or estimating liabilities; contingency reserve; risk factors; definitions

Sec. 205. (1) A health care corporation shall record or estimate liabilities at reasonable values, neither excessive nor inadequate, and in accordance with sound actuarial practices and generally accepted accounting principles, to provide for the payment of all debts of the corporation. The assets of the

corporation shall be valued in accordance with sound actuarial practices and generally accepted accounting principles. The commissioner shall disapprove the amount of any assets or liabilities which violate this subsection. The commissioner shall have the authority to disapprove the creation of any new liability which is properly includable in the contingency reserves. A liability shall be considered to be a new liability if the liability was not in existence on or before December 31, 1978.

(2) At all times while engaged in business, a health care corporation shall maintain a contingency reserve which, on a projected basis, progresses toward the target contingency reserve level established pursuant to this section. Until a target contingency reserve level is established pursuant to this section, the corporation shall maintain a contingency reserve in the form and amount determined by the commissioner, or 11.5% of the previous year's total incurred claims and incurred expenses, whichever is greater.

(3) Within 30 days after the filing of a health care corporation's annual financial statement under section 602, the commissioner shall determine the target contingency reserve level for the corporation, expressed as a percentage of the total incurred claims and incurred expenses of the corporation for the previous calendar year. The target shall be equal to the adjustment factor established in subsection (7) multiplied by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31. The commissioner shall transmit a copy of the target to the corporation, rounded up to the nearest 1/10 of a percent.

(4) A health care corporation, for purposes of this section, shall define at least 5 lines of business and shall assign a risk factor to each line of business. The risk factors shall be established in accordance with sound actuarial practices, and the health care corporation shall file these risk factors with the commissioner within 6 months after the following times:

(a) In the case of a health care corporation established under former Act No. 108 or 109 of the Public Acts of 1939, upon the effective date of this act.

(b) In the case of a health care corporation newly incorporated under this act, upon formation of the corporation.

(c) In the case of a health care corporation which has previously determined risk factors pursuant to this section, upon request of either the corporation or the commissioner, provided that the request is not made within 3 years after a previous determination of risk factors pursuant to this section, except as provided in subsection (8).

(5) Within 30 days after receipt of the risk factors filed pursuant to subsection (4), the commissioner shall do 1 of the following:

(a) Approve the factors and proceed under subsection (7).

(b) Define 1 or more additional lines of business, transmit the definitions to the health care corporation, and request that the corporation establish risk factors for those additional lines. The corporation shall then have 60 days to submit a risk factor for each line of business defined by either the commissioner or the corporation, which shall be approved or disapproved by the commissioner under this subsection. A health care corporation may revise a previously filed risk factor under this subsection.

(c) Disapprove the factors, and proceed under subsection (6).

(6) If the risk factors are disapproved by the commissioner pursuant to subsection (5)(c), the commissioner shall immediately notify the health care corporation of the disapproval. Within 6 months following notification, a panel of 3 actuaries, 1 appointed by the commissioner, 1 by the corporation, and 1 appointed by the 2 previously appointed actuaries, shall determine a risk factor for each line of business. The agreement of any 2 actuaries on the panel shall be sufficient for the determination of the risk factors, and the panel shall transmit a copy of the risk factors to both the commissioner and the corporation.

(7) Within 15 days after the determination of the risk factors under subsection (6), or the approval of the risk factors

under subsection (5)(a), the commissioner shall calculate an adjustment factor, which shall be transmitted to the health care corporation and the legislature. The adjustment factor shall equal:

(a) In the case of a filing pursuant to subsection (4)(a), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of December 31, 1979.

(b) In the case of a filing pursuant to subsection (4)(b), 11.5% divided by the sum of the risk factors weighted by the distribution of business of the corporation as of 6 months following the formation of the corporation.

(c) In the case of a filing pursuant to subsection (4)(c), the current target contingency reserve level divided by the sum of the risk factors weighted by the distribution of business of the corporation as of the previous December 31.

(8) At any time the health care corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth lines of business, risk factors for each line of business, and an adjustment factor.

(9) The contingency reserve of a health care corporation shall not be less than 65%, nor more than 120% of the target contingency reserve level. If the contingency reserve is above the required range at the end of a calendar year, the corporation shall implement adjustments as necessary to achieve the required range and shall file with the commissioner, for information, a description of the adjustments.

(10) The commissioner shall examine a health care corporation's annual financial statement filed in accordance with section 602 to determine, in accordance with generally accepted accounting principles, whether the contingency reserve is outside the required range described in subsection (9). If the contingency reserve is outside the required range at the end of 2 successive calendar years, the corporation shall file a plan, for approval by the commissioner, to adjust the contingency reserve to a level within the required range. If the commis-

sioner disapproves the corporation's plan, the commissioner shall formulate a plan and shall forward the plan to the corporation. The corporation shall begin implementation of the commissioner's plan immediately upon receipt of the plan in writing.

(11) Contributions to the contingency reserve shall consist of 2 contribution components. The first is the contribution for risk which shall be actuarially determined as a normal part of the rate-making process. The second is the contribution for plan-wide viability. Both components shall be considered contributions to the contingency reserve and shall be taken into consideration in determining compliance with this section.

(12) With respect to contributions for plan-wide viability, those contributions shall be made in accordance with the following:

(a) For contributions by small group and nongroup subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 95% of the target, the contribution rate shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 95% of the target, the contribution rate shall be 0%.

(b) For contributions by medium group and large group subscribers, if the contingency reserve is below 65% of the target, the contribution rate shall be 1% of the rate established pursuant to part 6; if the contingency reserve is between 65% and 105% of the target, the contribution shall be 0.5% of the rate established pursuant to part 6; if the contingency reserve is greater than 105% of the target, the contribution rate shall be 0%.

(c) At any time the corporation and the commissioner, by mutual agreement, may enter into a stipulation setting forth uniform adjustments to the contributions established in subdivisions (a) and (b).

(13) As used in this section:

(a) "Actuary" means a person who has the professional designation of a fellow of the society of actuaries, or a fellow of the society of casualty actuaries.

(b) "Distribution of business" means the percentage of a health care corporation's total business attributable to a given line of business, based on dollar amount of incurred claims and incurred expenses.

(c) "Risk factor" means the relative probability of loss associated with a given line of business, expressed as a percentage of incurred claims and incurred expenses for a calendar year.

(14) Arrangements for health benefit programs authorized under section 207(1)(f) shall not be included under this section unless, as part of the arrangement, contributions are made to the contingency reserve.

(15) The costs of a panel established under subsection (6) shall be split equally between a health care corporation and the commissioner, except that both the corporation and the commissioner shall pay the full costs associated with their appointed actuary.

550.1206. Funds and property; investments

Sec. 206. (1) The funds and property of a health care corporation shall be acquired, held, and disposed of only for the lawful purposes of the corporation and for the benefit of the subscribers of the corporation as a whole. A health care corporation shall only transact such business, receive, collect, and disburse such money, and acquire, hold, protect, and convey such property, as are properly within the scope of the purposes of the corporation as specifically set forth in section 202(1)(d), for the benefit of the subscribers of the corporation as a whole, and consistent with this act.

(2) The funds of a health care corporation shall be invested only in securities permitted by the laws of this state for the investments of assets of life insurance companies, as described

in chapter 9 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.901 to 500.947 of the Michigan Compiled Laws.

(3) Without regard to the limitation in subsection (2), up to 2% of the assets of the health care corporation may be invested in venture-type investments. For purposes of calculating the contingency reserve pursuant to section 205, a venture-type investment shall be carried on the books of a health care corporation at the original acquisition cost, and losses may only be realized as an offset against gains from venture-type investments. All venture-type investments under this subsection shall provide employment or capital investment primarily within this state. Each investment under this subsection shall be subject to prior approval by the board of directors. As used in this subsection, "venture-type investments" include:

(a) Common stock, preferred stock, limited partnerships, or similar equity interests acquired from the issuer subject to a provision barring resale without consent of the issuer for 5 years from the date of acquisition by the corporation.

(b) Unsecured debt instruments which are either convertible into equity or have equity acquisition rights. These debt instruments shall be subordinated by their terms to all borrowings of the issuer from other institutional lenders and shall have no part amortized during the first 5 years.

(4) A health care corporation shall not market or transact, as defined in sections 402a and 402b of Act No. 218 of the Public Acts of 1956, being sections 500.402a and 500.402b of the Michigan Compiled Laws, any type of insurance described in chapter 6 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.600 to 500.644 of the Michigan Compiled Laws. This subsection shall not be construed to prohibit the provision of prepaid health care benefits.

550.1207. Powers

Sec. 207. (1) A health care corporation, subject to any limitation provided in this act, in any other statute of this state, or in its articles of incorporation, may do any or all of the following:

(a) Contract to provide computer services and other administrative consulting services to 1 or more providers or groups of providers, if the services are primarily designed to result in cost savings to subscribers.

(b) Engage in experimental health care projects to explore more efficient and economical means of implementing the corporation's programs, or the corporation's goals as prescribed in section 504 and the purposes of this act, to develop incentives to promote alternative methods and alternative providers, including nurse midwives, nurse anesthetists and nurse practitioners, for delivering health care, including preventive care and home health care.

(c) For the purpose of providing health care services to employees of this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, or for the purpose of providing all or part of the costs of health care services to disabled, aged, or needy persons, contract with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States.

(d) For the purpose of administering any publicly supported health benefit plan, accept and administer funds, directly or indirectly, made available by a contract authorized under subdivision (c), or made available by or received from any private entity.

(e) For the purpose of administering any publicly supported health benefit plan, subcontract with any organization which has contracted with this state, the United States, or an agency, instrumentality, or political subdivision of this state or the United States, for the administration or furnishing of health services or any publicly supported health benefit plan.

(f) Provide administrative services only and cost-plus arrangements for the federal medicare program established by parts A and B of title XVIII of the social security act, 42 U.S.C. 1395c to 1395w; for the federal medicaid program established under title XIX of the social security act, 42 U.S.C. 1396 to 1396k; for the child health act of 1967, 42 U.S.C. 701

to 716; for the program of medical and dental care established by the military medical benefits amendments of 1966, Public Law 85-861, 80 Stat. 862; for the Detroit maternity and infant care—preschool, school, and adolescent project; and for any other health benefit program established under state or federal law.

(g) Provide administrative services only and cost-plus arrangements for any health benefit plan established by a subscriber group, subject to the requirements of section 211.

(h) Establish, own, and operate a health maintenance organization, subject to the requirements of Act No. 368 of the Public Acts of 1978, as amended.

(i) Guarantee loans for the education of persons who are planning to enter or have entered a profession that is licensed, or certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws, and has been identified by the commissioner, with the consultation of the office of health and medical affairs in the department of management and budget, as a profession whose practitioners are in insufficient supply in this state or specified areas of this state and who agree, as a condition of receiving a guarantee of a loan, to work in this state, or an area of this state specified in a listing of shortage areas for the profession issued by the commissioner, for a period of time determined by the commissioner.

(j) Receive donations to assist or enable the corporation to carry out its purposes, as provided in this act.

(k) Bring an action against an officer or director of the corporation.

(l) Designate and maintain a registered office and a resident agent in that office upon whom service of process may be made.

(m) Sue and be sued in all courts and participate in actions and proceedings, judicial, administrative, arbitrative, or otherwise, in the same cases as natural persons.

(n) Have a corporate seal, alter the seal, and use it by causing the seal or facsimile to be affixed, impressed, or reproduced in any other manner.

(o) Invest and reinvest its funds and, for investment purposes only, purchase, take, receive, subscribe for, or otherwise acquire, own, hold, vote, employ, sell, lend, lease, exchange, transfer, or otherwise dispose of, mortgage, pledge, use, and otherwise deal in and with, bonds and other obligations, shares, or other securities or interests issued by entities other than domestic, foreign, or alien insurers, as defined in sections 106 and 110 of Act No. 218 of the Public Acts of 1956, being sections 500.106 and 500.110 of the Michigan Compiled Laws, whether engaged in a similar or different business, or governmental or other activity, including banking corporations or trust companies. A health care corporation shall not guarantee or become surety upon a bond or other undertaking securing the deposit of public money.

(p) Purchase, receive, take by grant, gift, devise, bequest or otherwise, lease, or otherwise acquire, own, hold, improve, employ, use and otherwise deal in and with, real or personal property, or an interest therein, wherever situated.

(q) Sell, convey, lease, exchange, transfer or otherwise dispose of, or mortgage or pledge, or create a security interest in, any of its property, or an interest therein, wherever situated.

(r) Borrow money and issue its promissory note or bond for the repayment of the borrowed money with interest.

(s) Make donations for the public welfare, including hospital, charitable, or educational contributions which do not significantly affect rates charged to subscribers.

(t) Participate with others in any joint venture with respect to any transaction which the health care corporation would have the power to conduct by itself.

(u) Cease its activities and dissolve, subject to the commissioner's authority under section 606(2).

(v) Make contracts, transact business, carry on its operations, have offices, and exercise the powers granted by this act

in any jurisdiction, to the extent necessary to carry out its purposes under this act.

(w) Have and exercise all powers necessary or convenient to effect any purpose for which the corporation was formed.

(2) In order to ascertain the interests of senior citizens regarding the provision of medicare supplemental coverage, as described in section 202(1)(d)(v), and to ascertain the interests of senior citizens regarding the administration of the federal medicare program when acting as fiscal intermediary in this state, as described in section 202(1)(d)(vi), a health care corporation shall consult with the office of services to the aging and with senior citizens' organizations in this state.

(3) An act of a health care corporation, otherwise lawful, is not invalid because the corporation was without capacity or power to do the act. However, the lack of capacity or power may be asserted:

(a) In an action by a director or a member of the corporate body against the corporation to enjoin the doing of an act.

(b) In an action by or in the right of the corporation to procure a judgment in its favor against an incumbent or former officer or director of the corporation for loss or damage due to an unauthorized act of that officer or director.

(c) In an action or special proceeding by the attorney general to enjoin the corporation from the transacting of unauthorized business, to set aside an unauthorized transaction, or to obtain other equitable relief.

550.1208. Actions and proceedings; complaint

Sec. 208. (1) An action may be brought in the right of a health care corporation to procure a judgment in its favor, by a member of the corporate body.

(2) In such an action, the complaint shall allege:

(a) That the plaintiff is a member of the corporate body at the time of bringing the action, and that he or she was a member of the corporate body at the time of the transaction of which he or she complains.

(b) With particularity, the effort of the plaintiff to secure the initiation of the action by the board or the reasons for not making the effort.

550.1209. Discontinuance, compromise or settlement of actions

Sec. 209. An action authorized by section 208 shall not be discontinued, compromised, or settled without approval by the court having jurisdiction of the action. If the court determines that the interest of the members of the corporate body or of any component thereof will be substantially affected by the discontinuance, compromise, or settlement, the court may direct that notice, by publication or otherwise, be given to the members of the corporate body or any component thereof, whose interests it determines will be so affected. If notice is so directed to be given, the court may determine which 1 or more of the parties to the action shall bear the expense of giving the notice, in an amount which the court determines and finds reasonable under the circumstances. The amount of this expense shall be awarded as special costs of the action and shall be recoverable in the same manner as statutory taxable costs.

550.1210. Expenses of action

Sec. 210. (1) If an action brought in the right of the corporation is successful, in whole or in part, or if anything is received by the plaintiff or a claimant as a result of a judgment, compromise, or settlement of an action or claim, the court may award the plaintiff or claimant reasonable expenses, including reasonable attorney's fees, and shall direct him or her to account to the corporation for the remainder of the proceeds so received by him or her. This section does not apply to a judgment rendered for the benefit of an injured corporate body member only and limited to a recovery of the loss or damage sustained by him or her.

(2) In an action brought in the right of the corporation by a member of the corporate body, the court having jurisdiction, upon final judgment and finding that the action was brought without reasonable cause, may require the plaintiff to pay to

the parties named as defendants the reasonable expenses, including fees of attorneys, incurred by them in the defense of the action.

550.1211. Administrative services only or cost-plus contracts

Sec. 211. (1) Pursuant to section 207(1)(g), a health care corporation may enter into contracts containing an administrative services only or cost-plus arrangement. Except as otherwise provided in this section, a corporation shall not enter into a contract containing an administrative services only or cost-plus arrangement for a benefit plan covering less than 500 subscribers, except that a health care corporation may continue an administrative services only or cost-plus arrangement with a subscriber group of less than 500, which arrangement is in existence in September of 1980. A corporation may enter into contracts containing an administrative services only or cost-plus arrangement for a benefit plan covering less than 500 subscribers if either the corporation makes arrangements for excess loss insurance or the sponsor of the plan which covers the individuals is liable for the plan's liabilities and is a sponsor of 1 or more plans covering 500 or more individuals in the aggregate. The commissioner, upon obtaining the advice of the corporations subject to this act, shall establish the standards for the manner and amount of the excess loss insurance required by this subsection. It is the intent of the legislature that the excess loss insurance requirements be uniform as between corporations subject to this act and other persons authorized to provide similar services. An administrative services only or cost-plus arrangement for a group containing less than 2,000 subscribers shall include provisions which provide that if the group's claims for a given month exceed 150% of the projected average monthly claims for the group, the group shall have at least 3 months to pay the excess over 150% prior to termination of the arrangement. Arrangements subject to this section shall include provisions which establish the liability of the health care corporation for all claims incurred up to the date of termination of the arrangement. For purposes of this subsection, the number of subscribers in a group shall be computed without regard to the residence of the subscriber.

(2) Relative to actual administrative costs, fees for administrative services only and cost-plus arrangements shall be set in a manner which precludes cost transfers between subscribers subject to either of these arrangements and other subscribers of the health care corporation. Administrative costs for these arrangements shall be determined in accordance with the administrative costs allocation methodology and definitions filed and approved under part 6, and shall be expressed clearly and accurately in the contracts establishing the arrangements, as a percentage of costs rather than charges. This subsection shall not be construed to prohibit the inclusion, in fees charged, of contributions to the contingency reserve of the corporation, consistent with section 205.

(3) Before a health care corporation may enter into contracts containing administrative services only or cost-plus arrangements pursuant to section 207(1)(g), the board of directors of the corporation shall approve a marketing policy with respect to such arrangements which is consistent with the provisions of this section. The marketing policy may contain other provisions as the board considers necessary. The marketing policy shall be carried out by the corporation consistent with this act.

(4) A corporation providing services under a contract containing an administrative services only or cost-plus arrangement in connection with a noninsured benefit plan shall provide in its service contract a provision that the person contracting for the services in connection with a noninsured benefit plan shall notify each covered individual what services are being provided; the fact that individuals are not insured or are not covered by a certificate from the corporation, or are only partially insured or are only partially covered by a certificate from the corporation, as the case may be; which party is liable for payment of benefits; and of future changes in benefits.

(5) A service contract containing an administrative services only arrangement between a corporation and a governmental entity not subject to ERISA, whose plan provides coverage

under a collective bargaining agreement utilizing a policy or certificate issued by a carrier before the signing of the service contract, is void unless the governmental entity has provided the notice described in subsection (4) to the collective bargaining agent and to the members of the collective bargaining unit not less than 30 days before signing the service contract. The voiding of a service contract under this subsection shall not relieve the governmental entity of any obligations to the corporation under the service contract.

(6) Nothing in this section shall be construed to permit an actionable interference by a corporation with the rights and obligations of the parties under a collective bargaining agreement.

550.1212. Waiver of notice or lapse of time

Sec. 212. When, under this act or the articles of incorporation or bylaws of a health care corporation or by the terms of an agreement or instrument, a health care corporation or the board of directors of the health care corporation or any committee of the board may take action after notice to any person or after lapse of a prescribed period of time, the action may be taken without notice and without lapse of the period of time, if at any time before or after the action is completed the person entitled to notice or to participate in the action to be taken or, in case of a subscriber, by his or her attorney-in-fact, submits a signed waiver of those requirements. The attorney-in-fact may not be employed by, or receive substantial income from, the health care corporation.

550.1213. Indemnification; insurance on employees

Sec. 213. (1) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative, other than an action by or in the right of the health care corporation, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the

request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, judgments, fines, and amounts paid in settlement, actually and reasonably incurred by him or her in connection with the action, suit, or proceeding, if he or she acted in good faith and in a manner which he or she reasonably believed to be in, or not opposed to, the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had no reasonable cause to believe his or her conduct was unlawful. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole, and, with respect to any criminal action or proceeding, had reasonable cause to believe that his or her conduct was unlawful.

(2) A health care corporation may indemnify any person who was or is a party to, or is threatened to be made a party to, any threatened, pending, or completed action or suit by or in the right of the health care corporation to procure a judgment in its favor, by reason of the fact that he or she is or was a director, member of the corporate body, officer, employee, or agent of the health care corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise. This indemnification shall be against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection with the defense or settlement of the action or suit, if he or she acted in good faith and in a manner he or she reasonably believed to be in or not opposed to the best interests of the health care corporation, or its subscribers as a whole. However, indemnification shall not be made with respect to any

claim, issue, or matter as to which the person has been adjudged to be liable for negligence or misconduct in the performance of his or her duty to the health care corporation unless, and only to the extent that, the court in which the action or suit was brought determines upon application that, despite the adjudication of liability, but in view of all circumstances of the case, the person is fairly and reasonably entitled to indemnity for those expenses which the court considers proper.

(3) To the extent that a director, member of the corporate body, officer, employee, or agent of a health care corporation has been successful on the merits or otherwise in defense of any action, suit, or proceeding referred to in subsection (1) or (2), or in defense of any claim, issue, or matter therein, he or she shall be indemnified against expenses, including attorneys' fees, actually and reasonably incurred by him or her in connection therewith.

(4) Any indemnification under subsection (1) or (2), unless ordered by a court, shall be made by the health care corporation only as authorized in the specific case, upon a determination that indemnification of the director, member of the corporate body, officer, employee, or agent is proper in the circumstances because he or she has met the applicable standard of conduct set forth in subsections (1) and (2). The determination shall be made in any of the following ways:

(a) By the board by a majority vote of a quorum consisting of directors who were not parties to the action, suit, or proceeding.

(b) If such a quorum is not obtainable, by independent legal counsel in a written opinion.

(5) Expenses incurred in defending a civil or criminal action, suit, or proceeding described in subsection (1) or (2) may be paid by the health care corporation in advance of the final disposition of the action, suit, or proceeding, as authorized in the manner provided in subsection (4), upon receipt of an undertaking by or on behalf of the director, member of the

corporate body, officer, employee, or agent to repay that amount, unless it is ultimately determined that he or she is entitled to be indemnified by the corporation.

(6) A provision made to indemnify directors, members of the corporate body, or officers in any action, suit, or proceeding referred to in subsection (1) or (2), whether contained in the articles of incorporation, the bylaws, a resolution of the directors, an agreement, or otherwise, shall be invalid only insofar as it is in conflict with subsections (1) to (5) and this subsection. Nothing contained in subsections (1) to (5) and this subsection shall affect any rights to indemnification to which persons other than directors and officers may be entitled by contract or otherwise by law. The indemnification provided in subsections (1) to (5) and this subsection continues as to a person who has ceased to be a director, member of the corporate body, officer, employee, or agent, and shall inure to the benefit of the heirs, executors, and administrators of that person.

(7) A health care corporation may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the corporation, or is or was serving at the request of the health care corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against him or her and incurred by him or her in that capacity, or arising out of his or her status as described in this subsection, whether or not the health care corporation would have power to indemnify him or her against this liability under subsections (1) to (6).

(8) For the purposes of subsections (1) to (7), references to a health care corporation include all constituent corporations absorbed in a consolidation or merger and the resulting or surviving corporation, so that a person who is or was a director, officer, employee, or agent of a constituent corporation or is or was serving at the request of such a constituent corporation as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other

enterprise shall stand in the same position under the provisions of this section with respect to the resulting or surviving corporation as he or she would if he or she had served the resulting or surviving corporation in the same capacity.

550.1214. Interest paid in excess of legal rate

Sec. 214. A health care corporation may by agreement in writing, and not otherwise, agree to pay a rate of interest in excess of the legal rate, and in that case, the defense of usury is prohibited.

550.1215. Corporation as shareholder in other nonprofit corporations

Sec. 215. When a health care corporation, consistent with the purposes of the corporation prescribed in this act, is a shareholder in any other nonprofit corporation, its president and other officers or any of its directors may hold the office of director of the other nonprofit corporation the same as if they were individual shareholders in the other nonprofit corporation. The health care corporation, being a shareholder in the other nonprofit corporation, shall possess and exercise all the rights, powers, privileges, and liabilities of individual shareholders.

550.1216. Merger or consolidation

Sec. 216. (1) A health care corporation existing and authorized to do business under this act may merge into or consolidate with a corporation existing and authorized to do business under this act; Act No. 125 of the Public Acts of 1963, being sections 550.351 to 550.373 of the Michigan Compiled Laws; or part 210 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.21001 to 333.21099 of the Michigan Compiled Laws, by filing with the commissioner a plan of merger or consolidation adopted by a majority of the board members then in office in each constituent corporation.

(2) The plan of merger or consolidation shall set forth all of the following:

(a) The name and principal place of business of each constituent corporation and the name and principal place of

business of the surviving or consolidated corporation, which shall conform to the requirements set forth in section 202(1)(c).

(b) The number, qualifications, and identity or method of selection of the first board of directors or trustees of the surviving or consolidated corporation, and the term of existence of the surviving or consolidated corporation, which may be in perpetuity.

(3) The purpose of the surviving or consolidated corporation shall incorporate the purposes of each of the constituent corporations as set forth in their respective articles of incorporation in effect at the time of their respective adoptions of the plan of merger or consolidation.

(4) The filing of the plan of merger or consolidation shall be accompanied by a certificate of consolidation or a certificate of merger signed by the president or a vice-president and the secretary or an assistant secretary of each of the constituent corporations certifying that the plan of merger or consolidation was duly adopted by a majority of the board members of each of the constituent corporations in compliance with this section. The plan of merger or consolidation and the certificate shall be filed with the commissioner. The filing shall be accompanied by a filing fee of $10.00 to be deposited in the state treasury to the credit of the general fund. A copy of the certificate shall also be filed with the chief officer of the department of commerce or of any other agency or department authorized by law to administer Act No. 284 of the Public Acts of 1972, as amended, being sections 450.1101 to 450.2099 of the Michigan Compiled Laws, or his or her designated representatives.

(5) The surviving or consolidated corporation shall have all the rights, powers, privileges, immunities, and franchises, public or private, of each of the merging or consolidating corporations, including the rights, powers, privileges, immunities, and franchises of each of the merging or consolidating corporations under this act, and all property, real, personal and mixed, and all debts due on whatever account, and all other choses in action. All interests of or belonging to or due

to each of the corporations merged or consolidated shall be considered transferred to and vested in the surviving or consolidated corporation without further act or deed. The title to real estate, or any interest in real estate, vested in the corporation shall not revert or be in any way impaired because of the merger or consolidation. The surviving or consolidated corporation shall be responsible and liable for all liabilities and obligations of each of the corporations merged or consolidated.

(6) A claim existing or an action or proceeding pending by or against the health care corporation may be prosecuted as if the merger or consolidation had not taken place, or the surviving or consolidated corporation may be substituted in its place. The rights of creditors or a lien upon the property of the health care corporation shall not be impaired by the merger or consolidation.

(7) The plan of merger or consolidation shall become effective 30 days after filing with the commissioner for review and approval, unless the commissioner within that time serves written notice on the constitutent corporations designating those provisions of the proposed plan of merger or consolidation which do not satisfy the requirements of this act. In this case, the constitutent corporations may institute an action in the circuit court for Ingham county for an adjudication by that court as to whether the proposed plan of merger or consolidation filed with the commissioner of insurance satisfies the requirements of this act, and the court may make any order or grant any relief as it considers appropriate.

(8) The surviving or consolidated corporation shall continue to be subject to regulation by the commissioner to the same extent that is provided by this act.

550.1217. Escheat of assets after dissolution

Sec. 217. Upon dissolution of a health care corporation, the assets remaining after the payment of all debts of the corporation shall escheat to the state. Merger or consolidation under section 216 does not constitute dissolution within the meaning of this section.

PART 3.

550.1301. Board of directors

Sec. 301. (1) The property and lawful business of a health care corporation existing and authorized to do business under this act shall be held and managed by a board of directors to consist of not more than 35 members. The board shall exercise the powers and authority necessary to carry out the lawful purposes of the corporation, as limited by this act and the articles of incorporation and the bylaws of the corporation.

(2) Four voting members of the board shall be representatives of the public appointed by the governor by and with the advice and consent of the senate. Two of those members shall be retired individuals 62 years of age or older. The term of office of each representative of the public shall be 2 years, and until a successor is appointed and qualified. If a vacancy occurs before the conclusion of a 2-year term, the appointment of a representative to complete the term shall be made in the same manner as the original appointment.

(3) The board of directors shall consist of not more than 25% provider directors. In addition to physician and hospital provider directors, not less than 1 provider director shall be a registered professional nurse who shall be representative of licensees under part 172 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws, and not less than 1 provider director shall be representative of the provider whose services, in the calendar year immediately preceding the effective date of this act in the case of an existing health care corporation, or, in the calendar year immediately following incorporation in the case of a newly-formed health care corporation, generated the largest number of benefit claims received by the corporation from its subscribers. Other provider directors shall be as broadly representative of provider classes as possible.

(4) The bylaws of a health care corporation may authorize not more than 1 officer or employee of the corporation to serve as a voting or nonvoting director.

(5) The remaining members of the board of directors shall include representatives of large subscriber groups, medium subscriber groups, small subscriber groups, and nongroup subscribers, in proportions which fairly represent the total subscriber population of the health care corporation. However, at least 3 directors shall represent nongroup subscribers, at least 1 of whom shall be a retired individual 62 years of age or older, and at least 3 directors shall represent small subscriber groups. Large and medium subscriber groups shall be represented, to the greatest extent possible, by an equal number of labor and management representatives and shall be categorized as labor subscriber representatives or management subscriber representatives.

(6) The method of selection of the directors, other than the directors who are representatives of the public, and additional provisions and requirements for further refinement or specification regarding the number of directors comprising each component shall be specified in the bylaws. The terms of office of directors, other than the directors who are representatives of the public, and the method for filling vacancies in those offices shall be provided in the bylaws. However, if a term of office of more than 1 year is prescribed by the bylaws, at least ⅓ of the members of the board shall be selected each year.

(7) The method of selection of each category of subscribers entitled to representation on the board under subsection (5) shall maximize subscriber participation to the extent reasonably practicable. This subsection shall permit, but not require, the statewide election of a director or member of the corporate body. The method of selection shall neither permit nor require nomination, endorsement, approval, or confirmation of a candidate or director by the corporate body, the board of directors, or the management of the health care corporation, or any member or members of any of these. This subsection shall not apply to the selection of an officer or employee as a director pursuant to subsection (4). This subsection shall not limit the rights of any director, member of the corporate body, or employee or officer of the health care corporation to

participate in the selection process in his or her capacity as a subscriber, to the same extent as any other subscriber may participate.

(8) For the purposes of this section:

(a) "Health care provider" or "provider" includes:

(i) A person defined as a health care provider or provider in section 105(4); a person employed by a health care facility, as defined in section 105(3); or a director, officer, or trustee of a health care provider, as defined in section 105(4), unless the person serves in that capacity as a representative selected by the same subscriber group or collective bargaining representative which the person represents on the board of a health care corporation.

(ii) A spouse, child, or parent of a health care provider who resides in the same household.

(iii) A person who receives more than 25% of his or her annual income through the provision of goods or services to health care providers, or who is an employee, officer, trustee, or director of a firm or organization which receives more than 25% of its annual income through the provision of goods or services to health care providers.

(9) A director shall not be an employee, agent, officer, or director of an insurance company writing disability insurance inside or outside this state.

550.1302. Bylaws; adoption, amendment or repeal

Sec. 302. (1) The board of directors shall adopt initial bylaws and may amend or repeal those bylaws or adopt new bylaws, subject to the prior approval or certification by the attorney general. The bylaws may contain any provision for the regulation and management of the affairs of the health care corporation not inconsistent with the articles of incorporation, this act, or any other applicable provision of law.

(2) The initial bylaws, and any new bylaws, amendments, or repealers shall be submitted to the attorney general for review and approval. The attorney general shall approve the initial

bylaws, new bylaws, amendments, or repealers if the attorney general determines that they comply with this act.

(3) If the attorney general disapproves all or any part of the initial bylaws, new bylaws, amendments, or repealers, he or she shall return them to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest, not later than 30 days following their receipt. Bylaws, amendments, and repealers not returned to the health care corporation within this 30-day period shall be considered to comply with this act and shall be considered approved.

550.1303. Meetings of board or committees; quorum

Sec. 303. (1) Regular or special meetings of the board or a committee of the board shall be held within this state. With respect to regular or special meetings of the board or a committee of the board, the bylaws shall include provisions regarding all of the following:

(a) The minimum number of regular meetings to be held each year.

(b) The publication and advance distribution of an agenda, including provisions respecting the time and place of the meeting and the business to be conducted.

(c) Voting procedures. The use of proxies and round robins shall not be allowed.

(2) Notice of a regular meeting shall be given at least 15 days before the meeting and notice of a special meeting shall be given at least 24 hours before the meeting. Attendance of a director at a meeting constitutes a waiver of notice of the meeting, except in cases in which a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

(3) Unless otherwise restricted by the articles of incorporation or bylaws, a member of the board or of a committee designated by the board may participate in a meeting by means

of conference telephone or similar communications equipment by means of which all individuals participating in the meeting can hear each other. Participation in a meeting pursuant to this subsection constitutes presence in person at the meeting.

(4) A majority of the members of the board then in office, or of the members of a committee thereof, constitutes a quorum for the transaction of business, unless the articles or bylaws provide for a larger number. The vote of the majority of members present at a meeting at which a quorum is present constitutes the action of the board or of the committee, unless the vote of a larger number is required by this act, the articles, or the bylaws. The following actions shall require the vote of not less than a majority of the members of the board then in office:

(a) Adoption of bylaws, amendments to bylaws, or repealers of bylaws.

(b) Adoption of articles of incorporation, amendments to articles, or repealers of articles.

(c) The proposal or establishment of rates or rating systems; the adoption of provider class plans or provider contracts; or the adoption of compensation for officers of the corporation.

(5) The bylaws shall provide that a record roll call vote shall be taken at the request of any 5 board members. The vote of each member shall be recorded in the minutes.

550.1304. Books, records and minutes

Sec. 304. (1) A health care corporation shall keep accurate books and records of account and minutes of the proceedings of the board of directors of the health care corporation, committees of the board, and the corporate body. The books, records, and minutes may be in written form or in any other form capable of being converted into written form within a reasonable time. One copy of the minutes or draft minutes from each meeting of the board of directors shall be transmitted to the commissioner within 15 days after the meeting was held. Upon the request of a member of the board of directors, consistent with the board member's fiduciary duty under

section 310, a subscriber shall receive, within 15 days after receipt of the request, a copy of the minutes or draft minutes of 1 or more meetings of the board, its committee, or the corporate body, and may be charged not more than the reasonable cost of copying and postage.

(2) Minutes shall be kept and need not be disclosed, except to the commissioner as provided in section 603, for those portions of meetings which are held for the following purposes:

(a) To consider the hiring, promotion, dismissal, suspension, or discipline of an employee.

(b) To consider the purchase, lease, or sale of real property.

(c) For strategy and negotiation sessions connected with the negotiations of a collective bargaining agreement when either party requests a closed meeting.

(d) For trial or settlement strategy sessions in connection with specific contemplated or pending litigation. If these sessions are with respect to litigation to which the commissioner or the attorney general is a party, minutes regarding these sessions shall not be subject to examination and free access under section 603.

(e) To consider medical records of an individual.

(f) To consider the acquisition or disposal of certificates of stock, bonds, certificates of indebtedness, and other intangibles in which the corporation may invest funds under section 206, if the information regarding proposed acquisition or disposal may affect the price paid or received.

(g) To consider provider appeals when the provider has requested a closed hearing.

(h) To discuss marketing strategy with regard to a particular customer or limited group of customers, or to discuss a new or changed benefit, the premature disclosure of which would have an adverse impact on the health care corporation.

(i) To consider the removal of a director from the board when the director requests a closed hearing.

(3) The date and time of preparation and existence of the minutes described in subsection (2), the contents of which shall not be disclosable except to the commissioner as provided in section 603, shall be noted in the minutes required to be kept under subsection (1). Once action is taken by the board to implement a consideration or discussion described in subsection (2)(b), (f), (g), or (h), once a collective bargaining agreement is reached as described in subsection (2)(c), once litigation is no longer pending as described in subsection (2)(d), or once a closed hearing is concluded as described in subsection (2)(i), and upon the request of the director to whom the hearing pertained, the minutes relating to the consideration, discussion, or strategy session shall be published and disseminated with the next succeeding set of minutes published and disseminated under subsection (1), and may be disclosed by the commissioner to other persons under section 603(3).

(4) The circuit court, upon proof of a proper purpose, may compel the production of books and records for examination by a subscriber or the attorney general.

550.1305. Corporate body

Sec. 305. (1) A health care corporation may establish a corporate body. The corporate body shall consist of individuals selected in the same manner as individuals are selected to serve as nonpublic members on the board of directors. The size of the corporate body shall be such that, for each nonpublic voting director on the board of directors of the corporation, there are 2 members of the corporate body. The 4 public members selected pursuant to section 301(2) shall be considered to be members of the corporate body as well as members of the board of directors. An additional 4 public members shall be appointed to the corporate body by the governor by and with the advice and consent of the senate, 2 of whom shall be retired individuals 62 years of age or older.

(2) Members of the corporate body may serve on committees of the board of directors. A member of the corporate body may be selected for membership on the board of directors,

provided that the selection is made in accordance with the provisions of this part governing the selection of voting directors of the board.

550.1306. Contracts with directors or officers or with other corporations

Sec. 306. (1) A contract or other transaction between a health care corporation and 1 or more of its directors or officers, or between a health care corporation and any other corporation, firm, or association of any type or kind in which 1 or more of its directors or officers are directors or officers, or are otherwise interested, is not void or voidable solely because of such common directorship, officership, or interest, or solely because the directors are present at the meeting of the board or committee thereof which authorizes or approves the contract or transaction, if all of the following conditions are satisfied:

(a) The contract or other transaction is fair and reasonable to the corporation when it is authorized, approved, or ratified.

(b) The material facts as to the officer's or director's relationship or interest and as to the contract or transaction are disclosed or known to the board or committee, and the board or committee authorizes, approves, or ratifies the contract or transaction by a vote sufficient for the purpose. The conditions of this subdivision shall be considered satisfied only if the officer or director has announced the potential conflict prior to the vote, the minutes of the meeting reflect that announcement, and the officer or director abstained from the vote.

(2) When the validity of a contract described in subsection (1) is questioned, the burden of establishing its validity on the grounds prescribed is upon the director, officer, corporation, firm, or association asserting its validity.

(3) Common or interested directors shall not be counted in determining the presence of a quorum at a board or committee meeting at the time a contract or transaction described in subsection (1) is authorized, approved, or ratified.

(4) The board, by affirmative vote of a majority of directors in office and irrespective of any personal interest of any of them, may establish reasonable compensation of directors for services to the health care corporation as directors or officers of the health care corporation.

(5) The bylaws of a health care corporation may include provisions regarding conflict of interest which are more stringent than this section.

550.1307. Advisory councils and committees

Sec. 307. The board of directors may establish those advisory councils and, unless otherwise provided in the articles of incorporation or bylaws, those committees it considers necessary to perform its duties. Members of the corporate body may serve on committees of the board of directors. With respect to committees of the board, the bylaws shall include provisions regarding all of the following:

(a) Provisions which assure that the membership of each committee provides for representation of all of the components of directors, as defined in the bylaws, to the greatest extent practicable.

(b) Provisions regarding emergency meetings of the executive committee of the health care corporation, and action by that committee on behalf of the board in cases of emergency, as defined by the bylaws.

550.1308. Powers of committees

Sec. 308. (1) To the extent provided by resolution of the board or in the bylaws or articles, a committee established pursuant to section 307 may exercise the powers and authority of the board in management of the business and affairs of the health care corporation. The board shall review and may modify subject to the rights of third parties any action or decision of a committee. A committee shall not do any of the following:

(a) Amend the articles of incorporation.

(b) Adopt an agreement of merger or consolidation.

(c) Authorize the sale, lease, or exchange of all or substantially all of the corporation's property and assets.

(d) Approve, adopt, or amend provider contracts, provider class plans, rates charged to subscribers, or a certificate.

(e) Amend the bylaws of the corporation.

(f) Fill vacancies on the board.

(g) Fix compensation of the directors or officers.

(h) Perform other similar acts of a final or binding nature with respect to the business of the corporation.

(2) This section shall not prohibit emergency actions by the executive committee on behalf of the board, as authorized in the bylaws of the health care corporation.

550.1309. Officers and assistants; compensation; pensions

Sec. 309. (1) The board of directors shall select the officers of the health care corporation and a chairperson, vice-chairperson, and other board officers and assistants as the board considers necessary. However, an officer shall not execute, acknowledge, or verify an instrument in more than 1 capacity. Officers shall have only the authority, and assistants shall perform only those duties, in the management of the property and affairs of the corporation, as is provided in the bylaws or delegated to the officers and assistants by the board of directors, consistent with the bylaws. An officer or assistant may be removed by the board of directors with or without cause, subject to the contract rights, if any, of the officer or assistant. The selection of an officer or assistant does not of itself create contract rights. The board of directors may secure the fidelity of any or all of the officers by bond or otherwise. Unless otherwise provided in the articles or bylaws, the board of directors may fill vacancies in an office described in this subsection which occur for any reason.

(2) A health care corporation shall not pay a salary, compensation, or emolument to a director or officer unless the payment is first authorized by the board of directors of the corporation. A director, officer, assistant, or employee shall not be compensated unreasonably.

(3) A health care corporation shall not grant a pension to an officer or director, or to a member of the family of an officer or director after the death of the officer or director. However, the corporation, pursuant to the terms of a retirement plan adopted by the board of directors of the corporation and approved by the commissioner, may provide for any person who is or has been a salaried employee or officer of the corporation, a pension payable upon retirement, as provided in the approved retirement plan, and life insurance benefits payable at death.

550.1310. Fiduciary duties

Sec. 310. (1) With respect to management of the affairs and property of the health care corporation, and in the selection, supervision, and control of committees of the board, employees of the health care corporation, and officers, each director and officer, and the composite board, shall exercise the duties of a fiduciary toward the health care corporation and the subscribers of the health care corporation as a whole, and shall discharge his or her duties with the degree of diligence, care, and skill which an ordinarily prudent person would exercise under the same or similar circumstances in a like position. In discharging his or her duties, a director or officer, when acting in good faith, may rely upon the opinion of counsel for the corporation, upon the report of an independent appraiser selected with reasonable care by the board, or upon financial statements of the corporation represented to the director or officer to be correct by the president or the officer of the corporation having charge of its books of account, or stated in a written report by an independent public or certified public accountant or firm of such accountants fairly to reflect the financial condition of the corporation.

(2) After notice and a hearing before the board, a director may be removed from the board by a vote of ⅔ of the directors selected and serving on the board for a breach of fiduciary duty.

550.1311. Individual liability of directors or officers

Sec. 311. Each director or officer of a health care corporation shall be individually liable for the misapplication or misuse of corporate money or property caused through the neglect or failure of that director or officer to discharge his or her duties in compliance with the standards prescribed in section 310, or through wilful violation of this act or other laws governing the health care corporation.

550.1312. Limitation of actions against directors or officers

Sec. 312. An action against a director or officer for failure to perform the duties imposed by this act shall be commenced within 3 years after the cause of action has accrued, or within 2 years after the time when the cause of action is discovered, or should reasonably have been discovered, by a person complaining of the failure to perform, whichever occurs sooner.

550.1313. False statements or reports; limitation of actions

Sec. 313. (1) Except with respect to statements which are subject to prosecution for perjury, as defined in section 423 of Act No. 328 of the Public Acts of 1931, being section 750.423 of the Michigan Compiled Laws, a person, or an agent, director, or officer of a health care corporation, who knowingly makes any false oral or written statement as to a material fact, in or with respect to a report required by this act, or in the course of a hearing or examination held pursuant to this act, is guilty of a misdemeanor. In addition, the person, agent, director, or officer knowingly making the false statement and each person, agent, director, or officer knowingly authorizing, signing, or making the false report shall be jointly and severally personally liable to any person who has become a creditor of the health care corporation upon the faith of the false statement or the false report.

(2) An action for the civil liability imposed by this section shall be commenced within 2 years after discovery of the false statement or within 6 years after the report has been made by the person, agent, director, or officer of the health care corporation, whichever is sooner.

PART 4.

550.1401. Required and prohibited acts

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benfits that it will furnish, except as provided in this act, and may divide the health care benefits which it elects to furnish into classes or kinds.

(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(4) Nothing in subsection (3) shall prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group which had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act.

(6) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility which is to be used for acute care.

550.1401a. Dental services; benefits or reimbursement

Sec. 401a. (1) If a group or nongroup certificate of a health care corporation provides for health care benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section "dentist" means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to certificates which are issued or renewed on or after the effective date of this section, and shall apply notwithstanding any certificate provision to the contrary.

550.1401b. Mental health services benefits

Sec. 401b. A certificate issued by a corporation which provides benefits for mental health services shall provide benefits for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the

provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the corporation for all other providers of the type.

550.1402. Prohibited Acts

Sec. 402. (1) A health care corporation shall not do any of the following:

(a) Misrepresent pertinent facts or certificate provisions relating to coverage.

(b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

(c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

(d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.

(e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

(f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.

(g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

(h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.

(i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.

(j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent

of, the subscriber under whose certificate the claim is being made.

(k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

(*l*) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

(m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.

(2) In order to induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:

(a) Issue or deliver to the person money or any other valuable consideration.

(b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

(c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

(d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a certificate or contract for

administrative or other services, the benefits thereunder, or the true nature thereof.

(e) Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(4) The commissioner shall allow a health care corporation to participate in any trade practice conference for disability insurers convened under section 2047 of Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(5) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(6) When the commissioner has probable cause to believe that a health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), he or she shall give written notice to the corporation, pursuant to the administrative procedures act, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be

construed to diminish the right of a person to bring an action for damages under this section.

(7) A hearing held pursuant to subsection (6) shall be held in accordance with section 2030 of Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to the administrative procedures act. If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that the corporation is violating, or has violated subsection (2), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(8) A health care corporation which violates a cease and desist order of the commissioner issued under subsection (7), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than $10,000.00 for each violation.

(9) In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the member shall be awarded actual monetary damages or $200.00, whichever is greater, together with reasonable attorneys' fees. If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the

error, the amount of recovery shall be limited to actual monetary damages.

550.1403. Payment of benefits; claim forms

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.

(2) A health care corporation shall specify in writing the materials which constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation.

550.1404. Violations; informal managerial-level conference; review by commissioner

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, shall be entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall include all of the following:

(a) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(b) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person shall be entitled to a determination of the matter by the commissioner.

(4) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(5) If either the health care corporation or the person disagrees with a determination of the commissioner under this section, the commissioner, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

550.1405. Billing form; explanation of charges

Sec. 405. (1) A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be used in the place of forms developed pursuant to this subsection.

(2) A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.

550.1406. Confidentiality of records ensured by corporation

Sec. 406. (1) A health care corporation shall, in order to ensure the confidentiality of records containing personal data that may be associated with identifiable members, use reasonable care to secure these records from unauthorized access and to collect only personal data that are necessary for the proper review and payment of claims. Except as is necessary to comply with section 603 or for the purpose of claims adjudication, claims verification, or when required by law, a health care corporation shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member, to a person other than the member, without the prior and specific informed consent of the member to whom the data or information pertains. The member's consent shall be in writing. Except when a disclosure is made to the commissioner or another governmental agency, a court, or any other governmental entity, a health care corporation shall make a disclosure for which prior and specific informed consent is not required upon the condition that the person to whom the disclosure is made protect and use the disclosed data or information only in the manner authorized by the corporation, pursuant to subsection (2). If a member has authorized the release of personal data to a specific person, a health care corporation shall make a disclosure to that person upon the condition that the person shall not release the data to a third person unless the member executes in writing another prior and specific informed consent authorizing the additional release. This subsection shall not preclude the release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified. This subsection shall not preclude a representative of a subscriber group, upon request of a member of that subscriber group, or an elected official, upon request of a constituent, from assisting the individual in resolving a claim.

(2) The board of directors of a health care corporation shall establish and make public the policy of the corporation regarding the protection of the privacy of members and the confiden-

tiality of personal data. The policy, at a minimum, shall do all of the following:

(a) Provide for the corporation's implementation of provisions in this act and other applicable laws respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the corporation; prescribe the means by which members will be notified regarding such uses; and provide for notification regarding the actual release of personal data and information that may be identified with, or that concern, a member, upon specific request by that member. As used in this subdivision, "routine use" means the ordinary use or release of personal data compatible with the purpose for which the data were collected.

(c) Assure that no person shall have access to personal data except on the basis of a need to know.

(d) Establish the contractual or other conditions under which the corporation will release personal data.

(e) Provide that enrollment applications and claim forms developed by the corporation shall contain a member's consent to the release of data and information that is limited to the data and information necessary for the proper review and payment of claims, and shall resonably notify members of their rights pursuant to the board's policy and applicable law.

(f) Provide that applicants for new or renewed certificates shall be advised that the corporation does not require the use of the applicant's federal social security account number and that, when applicable, another authority does require use of the number.

(3) A health care corporation which violates this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

(4) A member may bring a civil action for damages against a health care corporation for a violation of this section and may recover actual damages or $200.00, whichever is greater, together with reasonable attorneys' fees and costs.

(5) This section shall not be construed to limit access to records or to enlarge or diminish the investigative and exami-

nation powers of governmental agencies, as provided for by law.

550.1407. Complaint system

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint which it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all the written complaints of its members which the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to the commissioner an annual report which describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. The report shall be compiled in a

manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

550.1408. False claims

Sec. 408. Any provider, member, or other person who knowingly makes, presents, or causes to be presented to a health care corporation any false, dishonest, or fraudulent claim for payment to or from the health care corporation, is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 or imprisonment for not more than 3 months, or both. This section shall not preclude a civil action for recovery of money due the corporation, nor shall it preclude the prosecution of any such provider, member, or other person under the applicable provisions of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.1 to 750.568 of the Michigan Compiled Laws.

550.1409. Negligence actions

Sec. 409. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a health care corporation.

550.1410. Dependent coverage for unmarried mentally retarded or physically handicapped children

Sec. 410. Any certificate issued by a health care corporation which provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days thereafter, the subscriber has submitted proof of the dependent's incapacity to the corporation.

550.1411. Supplemental medicare benefits certificate

Sec. 411. In addition to other supplemental medicare benefits certificates offered by the corporation, a health care corporation shall offer to all nongroup applicants at least 1 supplemental medicare benefits certificate without a preexisting condition exclusion or limitation. Such a certificate shall cover, at a minimum, the deductible and co-payment requirements of part A and part B of the federal medicare program at rates in accordance with rate standards set forth in section 608.

550.1412. Medicare supplemental buyer's guide

Sec. 412. (1) A health care corporation which provides a certificate to a person eligible for medicare shall provide the subscriber with a medicare supplemental buyer's guide.

(2) As used in this section, "medicare supplemental buyer's guide" means the document entitled, "guide to health insurance for people with medicare", which was developed by the national association of insurance commissioners and the United States department of health and human services, or a substantially similar document, as approved by the commissioner.

550.1413. Medicare coverage outline

Sec. 413. A corporation which offers a certificate to complement the federal medicare program shall provide to the applicant at the time of application a coverage outline in substantially the following form, as approved by the commissioner:

(HEALTH CARE CORPORATION NAME)
MEDICARE COMPLEMENTARY COVERAGE

1. READ YOUR CERTIFICATE CAREFULLY. This outline of coverage provides a very brief description of the important features of your certificate. This is not the certifi-

cate, and only the actual certificate provisions will control. The certificate itself sets forth in detail the rights and obligations of both you and your health care corporation. It is important that you read your certificate carefully.

2. Medicare has 2 parts. Part A covers many hospital costs. Part B covers many medical costs. If you are applying for a medicare supplemental certificate, but you are not enrolled in medicare part B, you should read this notice carefully. If you are not enrolled in medicare part B, it is probably to your advantage to buy medicare part B coverage before you consider buying a medicare supplemental certificate. Although the cost changes yearly, in [1980] medicare part B coverage was available at a cost of [$8.70] per month. This is an excellent buy because the federal government subsidizes more than ⅔ of the actual cost of the coverage. (The health care corporation issuing the certificate shall change the bracketed figures each year to reflect the proper figures.)

3. Medicare supplemental coverage—Certificates of this category are designed to supplement medicare by covering some hospital, medical, and surgical services which are partially covered by medicare. Coverage is provided for hospital inpatient charges and some physician charges, and for the deductibles and co-payment provisions required under medicare. The certificate does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if this coverage is provided in the certificate).

4. The (insert health care corporation's name) certificate is not connected with medicare.

5. (Insert health care corporation's name) is not connected with medicare.

6. The following is a brief summary of the major benefit gaps in medicare parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the medicare supplemental coverage:

Service	*Benefit*	*Medicare Pays*	*This Certificate Pays*	*You Pay*
Hospitalization	First 60 days	All but [$180.00]		
Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	61st to 90th day	All but [$45.00] a day		
Meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthesia, and rehabilitation services.	90th to 150th day	All but [$90.00] a day		
	Beyond 150 days	Nothing		
Posthospital skilled nursing care	First 20 days	100%		
In a facility approved by medicare, you must have been in a hospital for at least 3 days and enter the facility within 14 days after discharge from the hospital	Additional 80 days	All but [$22.50] a day		
	Beyond 100 days	Nothing		
Medical expenses	Physican's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy, and ambulance	80% of reasonable charge (after $60.00 deductible)		

(The corporation issuing the certificate shall change the bracketed figures each year to reflect current changes.)

7. A statement that the certificate does or does not cover the following:

(a) Private duty nursing.

(b) Skilled nursing home care costs beyond what is covered by medicare.

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care above number of visits covered by medicare.

(f) Physician charges above medicare's reasonable charge.

(g) Drugs other than prescription drugs furnished during a hospital or a skilled nursing facility stay.

(h) Care received outside of the United States.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, or examinations for eyeglasses or hearing aids.

8. A statement that the chart summarizing medicare benefits only briefly describes the benefits, and that the health care financing administration or its medicare publications should be consulted for further details and limitations.

9. The amount of the premium for this certificate.

550.1414. Alcoholism and drug abuse treatment coverage

Sec. 414. (1) A health care corporation established, maintained, or operating in this state shall offer benefits for the inpatient and outpatient treatment of alcoholism and drug abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of public health for the hospitalization for, or treatment of, alcoholism or drug abuse.

(2) A health care corporation subject to this act may enter into contracts for the rendering of alcoholism and drug abuse treatment with providers of inpatient or outpatient care for alcoholism and drug abuse. The provider shall be a licensed hospital or a substance abuse service program approved under

part 62 of Act No. 368 of the Public Acts of 1978, being sections 333.6201 to 333.6251 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

(3) This section shall expire January 1, 1982.

550.1414a. Inpatient treatment of substance abuse; contracting providers; intermediate and outpatient care for substance abuse.

Sec. 414a. (1) A health care corporation shall offer benefits for the inpatient treatment of substance abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of public health for the hospitalization for, or treatment of, substance abuse.

(2) A health care corporation may enter into contracts with providers for the rendering of inpatient substance abuse treatment by those providers. A contracting provider shall be a licensed hospital or a substance abuse service program approved under part 62 of Act No. 368 of the Public Acts of 1978, being sections 333.6201 to 333.6251 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

(3) A health care corporation shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all group and nongroup certificates other than service-specific certificates, such as certificates providing coverage solely for 1 of the following: dental care; hearing care; vision care; prescription drugs; or another type of health care benefit. A health care corporation may enter into contracts with providers for the rendering of intermediate care, outpatient care, or both types of care, for the treatment of substance abuse.

(4) In the case of group certificates, if the amount due for a group certificate would be increased by 3% or more because of the provision of the coverage required under subsection (3), the

master policyholder shall have the option to decline the coverage required to be provided under subsection (3). In the case of nongroup certificates, if the total amount due for all nongroup certificates of the health care corporation would be increased by 3% or more because of the provision of the coverage required under subsection (3), the subscriber for each such certificate shall have the option to decline the coverage required to be provided under subsection (3).

(5) Charges, terms, and conditions for the coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (3) shall not be less favorable than the maximum prescribed for any other comparable service.

(6) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (3) shall not be reduced by terms or conditions which apply to other items of coverage in a certificate, group or nongroup. This subsection shall not be construed to prohibit certificates that provide for deductibles and co-payment provisions for coverage for intermediate and outpatient care for substance abuse, as approved by the commissioner.

(7) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (3) shall, at a minimum, provide for up to $1,500.00 in health care benefits for intermediate and outpatient care for substance abuse per member per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(8) As used in this section:

(a) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for

individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(b) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(9) This section shall take effect January 1, 1982.

550.1415. Prosthetic device coverage

Sec. 415. (1) Not later than 12 months after the effective date of this act, a health care corporation shall offer or include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual whose covered illness or injury has required the removal of that body part. However, certificates resulting from collective bargaining agreements shall be exempted from this subsection. This coverage shall provide that reasonable charges for medical care and attendance for an individual fitted with a prosthetic device shall be covered

benefits after the individual's attending physician has certified the medical necessity or desirability for a proposed course of rehabilitative treatment.

(2) Not later than 12 months after the effective date of this act, a health care corporation shall include coverage, in all group and non-group certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this subsection.

550.1417. Hospice care benefits; contracts with health care providers, standard

Sec. 417. (1) A health care corporation shall offer to include benefits for hospice care in each certificate which is issued or renewed by a health care corporation after the effective date of this section and which provides benefits for inpatient hospital care, pursuant to this section.

(2) A health care corporation may enter into contracts with health care providers for the rendering of hospice care. A contracting health care provider shall be a licensed hospice under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22181 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care providers.

(3) This section shall take effect January 1, 1986.

PART 5.

550.1501. Contracts with health care facilities

Sec. 501. (1) A health care corporation subject to this act may enter into contracts with health care facilities.

(2) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

550.1502. Contracts with professional health care providers; provider class plan

Sec. 502. (1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services which the professional health care providers may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation: corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

(b) That the provider will accept payment from the corporation as payment in full for all cases involving the procedure specified, for the duration of the calendar year.

(c) That the provider will not determine whether to participate on a claim on the basis of the race, color, creed, marital status, sex, national origin, residence, age, handicap, or lawful occupation of the member entitled to health care benefits.

(2) A contract entered into pursuant to subsection (1) shall provide that the private provider-patient relationship shall be maintained to the extent provided for by law. A health care corporation shall continue to offer a reimbursement arrangement to any class of providers with which it has contracted prior to the effective date of this act and which continues to meet the standards set by the corporation for that class of providers.

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all

times have a choice of professional health care providers. This subsection shall not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, nor to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services which are overutilized, including those services rendered, ordered, or prescribed to an extent which is greater than reasonably necessary.

(4) A health care corporation may provide to a member, upon request, a list of providers with whom the corporation contracts, for the purpose of assisting a member in obtaining a type of health care service. However, except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or an individual on the board of directors of the corporation, shall not make recommendations on behalf of the corporation with respect to the choice of a specific health care provider. Except as otherwise provided in section 502a, an employee, agent, or officer of the corporation, or a person on the board of directors of the corporation who influences or attempts to influence a person in the choice or selection of a specific professional health care provider on behalf of the corporation, is guilty of a misdemeanor.

(5) A health care corporation shall provide a symbol of participation, which can be publicly displayed, to providers who participate on all claims for covered health care services rendered to subscribers.

(6) This section shall not be construed to impede the lawful operation of, or lawful promotion of, a health maintenance organization owned by a health care corporation.

(7) Contracts entered into under this section shall be subject to the provisions of sections 504 to 518.

(8) A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilties, is

licensed under part 208 of Act No. 368 of the Public Acts of 1978, being sections 333.20801 to 333.20821 of the Michigan Compiled Laws, and complies with part 221 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.22101 to 333.22181 of the Michigan Compiled Laws.

550.1502a. Prudent purchaser agreements, authorization, group and individual contracts; health care provider defined; rates; discrimination; termination

Sec.502a. (1) For the purpose of doing business as an organization under the prudent purchaser act, a health care corporation may enter into prudent purchaser agreements with health care providers pursuant to this section and the prudent purchaser act.

(2) A health care corporation may offer group contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) shall also be offered the option of being a subscriber under a contract pursuant to subsection (4). This subsection shall only apply if the group to which the individual is a member has 25 or more members or if the provider panel which is providing the services under the contract is limited by the organization to a specific number pursuant to section 3(1) of the prudent purchaser act.

(4) A health care corporation may offer group contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) or (4) shall also be offered the option of being a subscriber under a contract which:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) shall only apply if the group to which the individual is a member has 25 or more members and if the group on the effective date of this section had health care coverage through the group sponsor.

(7) A health care corporation may offer individual contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract which:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(8) A health care corporation may offer individual contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agree-

ments. A person to whom such a contract is offered shall also be offered a contract which:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(9) A health care provider who is not a member of the provider panel designated to render services to a person covered under a contract authorized by subsection (4) or (8), when rendering services to such person, shall receive payment from the corporation for such services in an amount which is 85% of the amount which is payable for the same services when rendered by a health care provider who is a member of the provider panel, subject to the following:

(a) A corporation may require as a condition of payment for services rendered under this subsection that the health care provider who is not a member of the provider panel shall be subject to the same utilization control standards and procedures as are applicable to health care providers who are members of the provider panel, including the standards filed with the commissioner pursuant to section 3(3)(c) of the prudent purchaser act.

(b) This subsection shall apply to a specific contract for only the first 2 years of the contract.

(c) As used in this subsection, "health care provider" means a person licensed under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws, but does not include a sanitarian or veterinarian.

(d) This subsection shall not apply after July 1, 1987.

(10) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the

corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(11) Contracts entered into under this section shall not be subject to the provisions of sections 504 to 518.

(12) A corporation shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection shall not be construed to:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when a service provided for in the specifications of a purchaser may be legally provided only by a single class of providers.

(b) Prohibit the formation of a provider panel which conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization which has uniformly applied the standards filed pursuant to section 3(3) of the prudent purchaser act to contract with any individual provider.

(13) Nothing in this 1984 amendatory act shall apply to any contract which is in existence before the effective date of this section, or the renewal of such contract.

(14) This section shall not apply after July 1, 1988.

550.1503. Uniform reporting by health care providers

Sec. 503. In the course of developing and establishing provider class plans under this part, a health care corporation shall address the issue of uniform reporting by health care providers.

550.1504. Goals of reimbursement arrangements with health care providers

Sec. 504. (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement

arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

(2) As used in this section:

(a) "Gross national product in constant dollars" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(b) "Implicit price deflator for gross national product" means that term as defined and annually published by the United States department of commerce, bureau of economic analysis.

(c) "Inflation" or "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross national product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made.

(d) "Compound rate of inflation and real economic growth" means the ratio of the quantity "100 plus inflation", multiplied by the quantity "100 plus real economic growth", to 100; minus 100; or as expressed in the following formula:

$$\left(\frac{(100 + I) \times (100 + REG)}{100} \right) - 100$$

(e) "Rate of change in the total corporation payment per member to each provider class" means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination.

(f) "Real economic growth" or "REG" means the arithmetic average of the percentage changes in the per capita gross national product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made.

(3) Nothing in this section shall preclude efforts by a health care corporation supplemental to the goals prescribed in subsection (1).

550.1505. Advice and consultation on plans

Sec. 505. (1) A health care corporation shall establish and implement procedures to obtain advice and consultation from a provider class, either through individual providers of that class or through 1 or more organizations or associations that represent the provider class, in any combination, in the development of the provider class plan. A health care corporation may negotiate with 1 or more organizations or associations that represent providers in the relevant provider class in the development and modification of the provider class plan and objectives and methods for implementing that plan.

(2) The commissioner shall establish and implement procedures whereby any person, including a subscriber, may offer advice and consultation on the development, modification, implementation, or review of a provider class plan.

(3) A health care corporation shall establish and implement procedures to obtain advice and consultation from subscribers in the development and modification of the provider class plan and objectives for implementing that plan.

550.1506. Transmission of plan to commissioner; examination

Sec. 506. (1) A health care corporation shall transmit a copy of each provider class plan to the commissioner 45 days before the earliest effective date of a provider contract or reimbursement arrangement for the appropriate provider class. The initial provider class plan for each class, which shall include provider contracts and reimbursement arrangements under which the corporation and a provider class are operating on the effective date of this act, shall be transmitted to the commissioner within 45 days after the effective date of this act, except where a provider class plan reimburses on a prospective basis, in which case the plan shall be transmitted within 1 year and 45 days after the effective date of this act.

(2) Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract. For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan.

(3) If the commissioner determines that the plan does not contain a reimbursement arrangement, objectives for each goal provided in section 504, and, for those providers with which a health care corporation contracts, contract provisions, the commissioner, within 15 days after receipt of the plan, shall notify the corporation by certified or registered mail, along with a written statement of the items omitted.

(4) If the commissioner does not notify the health care corporation pursuant to subsection (3), the provider class plan shall be automatically placed into effect, and shall be retained for the commissioner's records. Provider class plans approved by the commissioner or an independent hearing officer under this part shall be considered retained for the commissioner's records under this subsection.

550.1507. Items omitted from plan

Sec. 507. Within 15 days after receipt of the notification as provided in section 506(3), the health care corporation shall include the items omitted from the provider class plan, after taking into consideration any advice and consultation received from providers and subscribers pursuant to section 505, and shall transmit the items omitted, as provided in section 506(1).

550.1508. Modification of plans

Sec. 508. (1) Except during the 6-month period provided in section 509(2), a provider class plan retained by the commissioner as provided in section 506(4) may be modified by the health care corporation after the retention, under either of the following circumstances:

(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner.

(b) In all other cases, if the modification has been filed with and is agreed to by the commissioner.

(2) A modification made under subsection (1) shall not extend the time periods provided in section 509(1). In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2).

550.1509. Time for determination of achievement of goals

Sec. 509. (1) The commissioner may determine if the health care corporation has substantially achieved the goals of a corporation as provided in section 504 and achieved the objectives contained in the provider class plan, at the following times:

(a) For a provider contract or a reimbursement arrangement that was in effect prior to the effective date of this act, upon the expiration of 2 years after the filing date under section 506.

(b) For a provider class plan retained by the commissioner as provided in section 506(4), upon the expiration of 2 years after the earliest effective date of the provider contract or a reimbursement arrangement for the appropriate provider class.

(c) For a class plan retained by the commissioner as provided in section 506(4) that has not been subject to a determination under this section within the time period provided in subsection (2), within 2 years after the expiration of that time period.

(2) Before making a determination under subsection (1), and not later than 30 days following expiration of the appropriate 2-year time period described in subsection (1)(a), (b), or (c), the commissioner shall give written notice to the health care corporation, and to each person who has requested a copy of such notice, that he or she intends to make a determination with respect to a particular provider class plan. The commissioner shall have 6 months to reach a determination under subsection (1).

(3) A modification made pursuant to section 508(1) shall not be taken into consideration for purposes of computing the time periods described in subsections (1) and (2).

(4) The commissioner shall consider all of the following in making a determination pursuant to subsection (1):

(a) Annual reports transmitted pursuant to section 517.

(b) The overall balance of the goals provided in section 504, achieved by the health care corporation under the plan. The commissioner shall give weight to each of the goals provided in section 504, shall not focus on 1 goal independently of the other goals of the corporation, and shall assure that no portion of the corporations's fair share of reasonable costs to the provider are borne by other health care purchasers.

(c) Information submitted or obtained for the record concerning: demographic trends; epidemiological trends; and long-term economic trends, including changes in prices of goods and services purchased by a provider class not already reflected in the calculation in section 504(2)(d); sudden changes

in circumstances; administrative agency or judicial actions; changes in health care practices and technology; and changes in benefits that affect the ability of the health care corporation to reasonably achieve the goals provided in section 504.

(d) Health care legislation of this state or of the federal government. As used in this subdivision, "health care legislation" does not include Act No. 218 of the Public Acts of 1956, as amended, being sections 500.100 to 500.8302 of the Michigan Compiled Laws.

(e) Comments received from an individual provider of the appropriate provider group, or from an organization or association that represents the appropriate provider class, and comments received pursuant to section 505(2).

(5) In making a determination pursuant to subsection (1), the commissioner shall provide a detailed statement of findings which support that determination, including a consideration of the information and factors described in subsection (4).

(6) All data, analyses, and factors, quantified or otherwise, at a minimum, shall include the 2-year period being evaluated.

(7) The commissioner shall make a sufficient number of determinations regarding provider class plans under this section, so that during each 3-year period following the effective date of this act, there is a review of provider class plans which, taken together, account for at least 75% of the total corporation payout to providers for the 3-year period.

(8) Determinations by the commissioner shall not be contested case hearings under chapter 4 of the administrative procedures act. This subsection shall not be construed to apply with respect to appeals under section 515.

550.1510. Determination of achievement of goals

Sec. 510. (1) After considering the information and factors described in section 509(4), the goals of a health care corporation as provided in section 504, and the objectives contained in the provider class plan, the commissioner shall determine 1 of the following:

(a) That the provider class plan achieves the goals of the corporation as provided in section 504.

(b) That although the provider class plan does not substantially achieve 1 or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve 1 or more of the goals was reasonable due to factors listed in section 509(4).

(c) That a provider class plan does not substantially achieve 1 or more of the goals of the corporation as provided in section 504.

(2) The commissioner shall notify the health care corporation, and each person who has requested a copy of such notice, of a determination under subsection (1) by certified or registered mail. Determinations made pursuant to subsection (1)(b) or (c) shall include a concise written statement of specific findings supporting that determination.

(3) An existing provider contract or reimbursement arrangement shall remain in effect until a new provider class plan has been retained and placed into effect as provided in section 506(4). A provider class plan shall not be subject to further review until the expiration of the time period provided in section 509(1).

(4) A provider class plan with respect to which a determination was made under subsection (1)(a) or (b) shall not be subject to further review until the expiration of 2 years following the determination.

550.1511. Transmission of new plan after determination of non-achievement of goals

Sec. 511. (1) Upon receipt of notice under section 510(2), the health care corporation, within 6 months or a period determined by the commissioner pursuant to section 512, shall transmit to the commissioner a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the

findings made by the commissioner pursuant to section 510(2). In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(2) If, after the expiration of 6 months or a period determined by the commissioner pursuant to section 512, the health care corporation has failed to act pursuant to subsection (1), the commissioner shall prepare a provider class plan pursuant to section 513(2)(a), for that provider class.

550.1512. Extension of time for transmission of new plan

Sec. 512. The commissioner may extend the 6-month period provided in section 511(1) once, for not more than 90 days, if the commissioner determines that a health care corporation requires additional time to assess the findings made by the commissioner or to prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. In making a determination under this section, the commissioner shall consider the number of provider class plans, the extent of the changes to each plan, and the stage of development of each plan being prepared by the health care corporation pursuant to section 511(1).

550.1513. Redetermination of achievement of goals by new plan

Sec. 513. (1) Upon receipt of a provider class plan under section 511(1), the commissioner, after considering the information and factors described in section 509(4), within 90 days shall examine the plan and determine if the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner. If the commissioner determines that the plan substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner, the plan shall be automatically retained and placed into effect as provided in section 506.

(2) If the commissioner determines that the plan does not substantially achieve the goals, does not achieve the objectives, and does not substantially overcome the deficiences enumerated in the findings made by the commissioner pursuant to section 510(2), the commissioner shall do all of the following:

(a) Prepare a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made pursuant to section 510(2), and transmit that plan to the health care corporation. A provider class plan prepared pursuant to this subdivision shall be retained for the commissioner's records and placed into effect as provided in section 506(4), unless a request for an appeal is made under subdivision (b).

(b) Give written notice to the health care corporation of an opportunity for an appeal pursuant to section 515. The notice shall state that a request for an appeal shall be made by the corporation within 30 days after the receipt of notice under this subdivision.

(3) In making a determination pursuant to subsection (1), or preparing a plan pursuant to subsection (2)(a), the commissioner shall obtain advice and consultation pursuant to section 505(2). The commissioner shall also forward a copy of each notice issued under subsection (2)(b) to each person requesting a copy. The copy shall notify the person of an opportunity for an appeal pursuant to section 515, and that a request for such an appeal is required to be made within 30 days after the receipt of notice given under this subsection.

550.1514. Appeals; hearing officers

Sec. 514. (1) All appeals under this part shall be held before an independent hearing officer. The state court administrator shall compile and maintain a list of individuals possessing all of the following qualifications:

(a) Is a retired circuit court judge.

(b) Is a resident of this state.

(c) Is not engaged in the provision of health care services.

(d) Is not an officer or employee of a health care provider, health care corporation, or an employee of this state. For purposes of this subdivision, an employee of an educational institution shall not be considered to be employed by this state.

(2) The hearing officer shall be selected at random by the commissioner from the list described in subsection (1), on a per appeal basis. If the individual selected is performing judicial duties, another individual shall be selected.

(3) The hearing officer shall have the power to consolidate appeals related to a provider class.

(4) The commissioner shall prepare and file with the appropriate standing committees of the legislature an annual report regarding the operation of the appeals procedure prescribed in this part, including data regarding the identity of individuals available to serve as independent hearing officers whose names are on the administrator's list; the number of appeals heard; the nature of the controversy involved; the disposition of the appeal; and whether a judicial appeal was subsequently taken, and the disposition of that appeal.

550.1515. Appeals; persons eligible to appeal

Sec. 515. (1) An appeal may be brought from any action or determination of the commissioner under section 509(1), 510(1), or 513(1) or (2), by a subscriber, the health care corporation, the attorney general, an employer, an organization or association representing a subscriber or an employer, or an organization or association representing the affected provider class. An appeal may also be brought by a person whose contractual or legal rights, duties, or privileges are substantially affected. The request for an appeal shall identify the issue or issues which the affected party asserts are involved, and how the party is aggrieved. The independent hearing officer shall determine the standing of any party to appeal.

(2) An appeal from an action or determination of the commissioner under this part shall be brought within 30 days after the action or determination. All appeal hearings shall begin within 30 days after receipt of a request for an appeal.

The appeal shall be conducted pursuant to chapter 4 of the admistrative procedures act.

(3) In an appeal pursuant to this section, the relief available to a person, and the decision of an independent hearing officer hearing an appeal, shall be limited to the following:

(a) Affirming or reversing a determination of the commissioner under sections 509(1) and 510(1).

(b) Determining, based on the information and factors described in section 509(4) and the standards prescribed in section 516, 1 of the following:

(i) That the provider class plan prepared by the corporation under section 511(1) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(ii) That the provider class plan prepared by the commissioner under section 513(2)(a) was prepared in compliance with that section and shall be retained as provided in section 506(4).

(iii) That a provider class plan described in subparagraph (i) or (ii) was not prepared in compliance with section 511(1) or 513(2)(a), respectively, and shall not be retained as provided in section 506(4). In this case, the hearing officer shall order the corporation to prepare and submit a provider class plan as provided in subsection (4). Detailed findings must accompany the determination made by the hearing officer pursuant to this subdivision.

(4) Within 180 days after receipt of the hearing officer's determination made under subsection (3)(b)(iii), the health care corporation shall transmit to the hearing officer a provider class plan that is in conformance with the findings of the hearing officer and that substantially achieves the goals of a health care corporation as provided in section 504. In developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505.

(5) After receipt of a provider class plan transmitted by the health care corporation pursuant to subsection (4), the hearing officer shall determine 1 of the following:

(a) That the provider class plan prepared by the corporation shall be retained as provided in section 506(4).

(b) That the provider class plan prepared by the corporation should not be retained as provided in section 506(4), and the commissioner may suspend or limit the corporation's certificate of authority until the corporation submits a provider class plan which the hearing officer determines should be retained as provided in section 506(4).

550.1516. Provider class plans; standards

Sec. 516. (1) All provider class plans retained by the commissioner under section 513 or approved by the hearing officer shall maintain the following standards for all providers:

(a) Responsible cost controls shall exist that balance quality, accessibility, and cost.

(b) The health care corporation shall promote programs and policies which encourage cost-effective behavior by providers in accordance with the provisions of this act, and in accordance with all of the following:

(i) There shall be a reasonable basis for believing that the programs will be effective.

(ii) The programs applicable to a provider class shall be reviewed to avoid duplication or inconsistency, to the extent practicable.

(c) There shall be a fair and reasonable appeals process established and maintained by the health care corporation for aggrieved providers.

(d) There shall be a reasonable period for implementation of changes.

(e) There shall be reasonably prompt payment by the health care corporation to providers who render covered health care services.

(2) In addition to the standards prescribed in subsection (1), the following standards shall apply to hospitals:

(a) To the extent practicable, reimbursement control shall be expressed in the aggregate to individual hospitals.

(b) No portion of the health care corporation's fair share of hospitals' reasonable financial requirements shall be borne by other health care purchasers. However, this subdivision shall not preclude reimbursement arrangements which include financial incentives and disincentives.

(c) The health care corporation's programs and policies shall not unreasonably interfere with the hospital's ability and responsibility to manage its operations.

550.1517. Annual reports for provider classes

Sec. 517. A health care corporation shall transmit an annual report for each provider class to the commissioner regarding the level of achievement of the goals provided in section 504. The report shall include data necessary to a determination of the corporation's compliance or noncompliance with the goals, as prescribed in section 504, and compliance with objectives contained in the provider class plan. The report shall be in accordance with forms and instructions prescribed by the commissioner and shall include information as necessary to evaluate the considerations of section 509(4). The report may include other information the corporation deems relevant.

550.1518. Appeals; grounds, procedures

Sec. 518. The considerations set forth in section 509(4) and the standards set forth in section 516 shall only apply for purposes of this act and may be appealed only as specifically provided in this act. An appeal from a final determination of an independent hearing officer shall be conducted pursuant to chapter 6 of the administrative procedures act, except that the appeal shall be taken within 30 days after the final determination, upon leave granted, in the court of appeals.

PART 6.

550.1601. Regulation and supervision by commissioner; designee

Sec. 601. (1) A health care corporation shall be subject to regulation and supervision by the commissioner as provided in this act.

(2) A designee of the commissioner shall not be authorized to act on behalf of the commissioner under this act unless prior written notice of the delegation of authority has been given to a health care corporation subject to that delegated authority.

550.1602. Annual statement of condition of corporation; reports

Sec. 602. (1) Not later than March 1 each year, subject to a 30-day extension which may be granted by the commissioner, a health care corporation shall file in the office of the commissioner a sworn statement verified by at least 2 of the principal officers of the corporation showing its condition as of the preceding December 31. The statement shall be in a form, and contain those matters, which the commissioner prescribes for a health care corporation, including those matters contained in section 205. The statement shall include the number of members and the number of subscribers' certificates issued by the corporation and outstanding.

(2) The commissioner, by order, may require a health care corporation to submit statistical, financial, and other reports for the purpose of monitoring compliance with this act.

550.1603. Visitation and examination by commissioner

Sec. 603. (1) The commissioner shall have the power of visitation and examination into the affairs of a health care corporation. The corporation shall in every way facilitate an examination or visitation.

(2) The power of examination shall include free access to all of the books, papers, and documents that relate to the business of the corporation, except as provided in section 304(2)(d). Free access shall include the right to copy and reproduce at the

place of business of the health care corporation and to require delivery of any materials to the office of the commissioner in Lansing within 5 working days after the request is made. If the corporation is unable to respond to the request within 5 working days, the corporation shall specify a date certain by which the corporation will respond. However, the date certain shall not be later than 15 working days after the request is made unless the commissioner agrees to a longer period of time. Witnesses may be summoned and qualified under oath, and examination may be made of the corporation's officers, agents, or employees or of other persons having knowledge of the affairs, transactions, and conditions of the corporation. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(3) Information provided to the commissioner which is disclosable only to the commissioner under section 304(2) shall not be disclosed by the commissioner to other persons until such time as the minutes pertaining to that information may be disclosed under section 304(3).

(4) If it appears from any examination or report that this act or any other law of this state has been violated, the commissioner immediately shall report the violation to the attorney general in writing. The attorney general shall then take action on the alleged violation, as the facts warrant. Unless the public health, safety, or welfare otherwise clearly requires, before commencement of a proceeding against a health care corporation resulting from a report, the corporation shall be furnished a copy of the examination report and shall be given an informal opportunity to show compliance with law.

(5) Upon the request of the commissioner, the attorney general may petition for, and the circuit court may issue, an ex parte order from the circuit court directing a corporation to comply with this section. The corporation shall be entitled to an expedited hearing to challenge the ex parte order.

550.1604. Confidentiality of records ensured by commissioner

Sec. 604. (1) The commissioner shall ensure that confidentiality of records containing personal data which may be associated with identifiable individuals. Except as is necessary to comply with a court order, or for the purposes of claim adjudication or when required by law, the commissioner shall not disclose records containing personal data which may be associated with an identifiable individual without the prior informed consent of the individual to whom the data pertain. The individual's consent shall be in writing. If an individual has authorized the release of personal data to a specific person, that person shall not release the data to a third person unless the individual executes in writing another informed consent authorizing that additional release.

(2) The commissioner shall ensure the confidentiality of data which discloses reimbursement levels for specific procedures or services of specific providers and data which, if disclosed, can be used to calculate those reimbursement levels. This subsection shall apply only if the data are not already generally known to providers and if the disclosure of the data would be harmful to the achievement of the goals set forth in section 504. Only that portion of a record dealing with data described in this subsection shall be exempt from disclosure. A person, whose request for a hearing has been granted by the commissioner, may examine the data and shall be subject to the same confidentiality requirements as the commissioner under this subsection.

(3) The commissioner shall ensure the confidentiality of any trade secrets of the corporation, except for information required to be disclosed under Act No. 442 of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(4) Subject to the provisions of subsections (1) to (3), information which a health care corporation provides to or files with the commissioner shall be governed by Act No. 442

of the Public Acts of 1976, as amended, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

(5) A person who violates the confidentiality provisions of this section is guilty of a misdemeanor, punishable by a fine of not more than $1,000.00 for each violation.

550.1605. Suspension or limitation of certificate of authority

Sec. 605. (1) Upon due notice and an opportunity for an evidentiary hearing pursuant to the administrative procedures act, the commissioner may suspend or limit the certificate of authority of a health care corporation if the commissioner determines that any of the following circumstances exist:

(a) The health care corporation does not meet the requirements of this act respecting the adequacy of its reserves.

(b) The health care corporation is using methods or practices in the conduct of its business which render further transactions hazardous or injurious to subscribers of the corporation or the public.

(c) The health care corporation refuses or fails to comply with this act or with a lawful order of the commissioner.

(2) If the commissioner finds that the public health, safety, or welfare requires emergency action and incorporates this finding into an order, a summary suspension or limitation of a certificate of authority may be ordered. The suspension or limitation shall be effective on the date specified in the order or upon service of a certified copy of the order on the health care corporation, whichever is later, and shall be effective during the proceedings. The corporation shall have the right to an administrative hearing within 5 days to show why the summary suspension or limitation should be terminated.

(3) An order of limitation may restrict the solicitation of certificates, the renewal of business in force, and the solicitation, offer, or acceptance of contracts, and may impose other conditions to continued authorization as are reasonably necessary to protect the subscribers of the corporation or the public. The commissioner shall terminate an order of limitation when the circumstance giving rise to the order ceases to exist.

(4) Upon suspension or limitation of a corporation's certificate of authority, if the commissioner considers it necessary or desirable for the protection of the subscribers of the corporation or the public, the commissioner may publish notice of the suspension or limitation in 1 or more newspapers of general circulation in the state.

(5) An emergency order by the commissioner which suspends or limits a corporation's certificate of authority shall be for a period not to exceed 1 year and, after opportunity of hearing, the commissioner for good cause may extend the period of suspension or limitation for additional periods not to exceed 1 year.

550.1606. Authority of commissioner concerning officers and directors, dissolution, take-overs or liquidation

Sec. 606. (1) The commissioner shall have the same authority regarding the officers and directors of a health care corporation as the commissioner has with respect to the officers and directors of insurers under sections 249 and 250 of Act No. 218 of the Public Acts of 1956, being sections 500.249 and 500.250 of the Michigan Compiled Laws.

(2) The commissioner shall have the same authority with respect to the dissolution, taking over, or liquidation of corporations formed or doing business under this act as is provided in chapter 78 of Act No. 218 of the Public Acts of 1956, as amended, being sections 500.7800 to 500.7868 of the Michigan Compiled Laws. For purposes of this subsection, a health care corporation shall be considered to be insolvent if its liabilities exceed its assets, unless otherwise defined in chapter 78 of Act No. 218 of the Public Acts of 1956, as amended.

550.1607. Submission of new or revised certificates and proposed rates and rate rationale

Sec. 607. (1) A health care corporation shall submit a copy of any new or revised certificate to the commissioner along with applicable proposed rates and rate rationale. The certificates, and applicable proposed rates, shall be deemed approved

and effective 30 days after filing with the commissioner, except as otherwise provided in this section. The commissioner may subsequently disapprove any certificate deemed approved.

(2) The commissioner shall exempt from prior approval certificates resulting from a collective bargaining agreement.

(3) The commissioner may disapprove, or approve with modifications, a certificate and applicable rates under 1 or more of the following circumstances:

(a) If the rate charged for the benefits provided is not equitable, not adequate, or excessive, as defined in section 609.

(b) If the certificate contains 1 or more provisions which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation of the coverage.

(c) If a certificate reduces the scope, amount, or duration of benefits so as to have the effect of reducing the comprehensiveness of existing health care benefits available to groups or to individuals. The commissioner may approve a certificate which reduces the scope, amount, or duration of health care benefits if the commissioner determines that the certificate will be offered as an alternative in addition to an existing certificate which provides comprehensive health care benefits and if the commissioner determines that approval of the alternative certificate will not adversely affect the opportunity for groups or individuals to obtain comprehensive health care benefits.

(4) The commissioner shall approve a certificate and applicable proposed rates if all of the following conditions are met:

(a) If the rate charged for the benefits provided is equitable, adequate, and not excessive, as defined in section 609.

(b) If the certificate does not contain any provision which is unjust, unfair, inequitable, misleading, deceptive, or which encourages misrepresentation of the coverage.

(5) If the commissioner disapproves a certificate and any applicable proposed rates under this section, he or she shall issue a notice of disapproval which specifies in what respects a filing fails to meet the requirements of this act. The notice shall state that the filing shall not become effective.

(6) If the commissioner approves, or approves with modifications, a certificate and any applicable proposed rates under this section, he or she shall issue a notice of approval or approval with modifications. If the notice is of approval with modifications, the notice shall specify what modifications in the filing are required for approval under this act, and the reasons for the modifications. The notice shall also state that the filing shall become effective after the modifications are made and approved by the commissioner.

(7) Upon request by a health care corporation, the commissioner may allow certificates and rates to be implemented prior to filing to allow implementation of a new certificate on the date requested.

550.1608. Filing of rates for nongroup subscribers; methodology and definitions; time for effect for proposed rates

Sec. 608. (1) The rates charged to nongroup subscribers for each certificate shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. Annually, the commissioner shall approve, disapprove, or modify and approve the proposed or existing rates for each certificate subject to the standard that the rates must be determined to be equitable, adequate, and not excessive, as defined in section 609. The burden of proof that rates to be charged meet these standards shall be upon the health care corporation proposing to use the rates.

(2) The methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers for each certificate, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements, shall be filed in accordance with section 610 and shall be subject to the prior approval of the commissioner. The definition of a group, including any clustering principles applied to nongroup subscribers or small group subscribers for the purpose of group formation, shall be subject to the prior approval of the

commissioner. The commissioner shall approve, disapprove, or modify and approve the methodology and definitions of each rating system, formula, component, and factor for each certificate subject to the standard that the resulting rates for group subscribers must be determined to be equitable, adequate, and not excessive, as defined in section 609. In addition, the commissioner may from time to time review the records of the corporation to determine proper application of a rating system, formula, component, or factor with respect to any group. The corporation shall refile for approval under this subsection, every 3 years, the methodology and definitions of each rating system, formula, component, and factor used to calculate rates for group subscribers, including the methodology and definitions used to calculate administrative costs for administrative services only and cost-plus arrangements. The burden of proof that the resulting rates to be charged meet these standards shall be upon the health care corporation proposing to use the rating system, formula, component, or factor.

(3) A proposed rate shall not take effect until a filing has been made with the commissioner and approved under section 607 or this section, as applicable, except as provided in subsections (4) and (5).

(4) Upon request by a health care corporation, the commissioner may allow rate adjustments to become effective prior to approval, for federal or state mandated benefit changes. However, a filing for these adjustments shall be submitted before the effective date of the mandated benefit changes. If the commissioner disapproves or modifies and approves the rates, an adjustment shall be made retroactive to the effective date of the mandated benefit changes or additions.

(5) Implementation prior to approval may be allowed when the health care corporation is participating with 1 or more health care corporations to underwrite a group whose employees are located in several states. Upon request from the commissioner, the corporation shall file with the commissioner, and the commissioner shall examine, the financial arrangement, formulae, and factors. If any are determined to be unacceptable, the commissioner shall take appropriate action.

550.1609. Factors considered in determining reasonableness of rate; administrative expense budget; cost transfers

Sec. 609. (1) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively; provision for anticipated benefit costs; provision for administrative expense; provision for cost transfers, if any; provision for a contribution to or from the corporate contingency reserve that is consistent with the attainment or maintenance of the target contingency reserve level prescribed in section 205; and provision for adjustments due to prior experience of groups, as defined in the group rating system. A determination as to whether a rate is excessive relative to the elements listed above, individually or collectively, shall be based on the following: reasonable evaluations of recent claim experience; projected trends in claim costs; the allocation of administrative expense budgets; and the present and anticipated contingency reserve positions of the health care corporation. To the extent that any of these elements are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(2) The administrative expense budget must be reasonable, as determined by the commissioner after examination of material and substantial administrative and acquisition expense items.

(3) A rate is equitable if the rate can be compared to any other rate offered by the health care corporation to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(4) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in claim costs, the allocation of administrative expense budgets, and the present and antici-

pated contingency reserve positions of the health care corporation.

(5) Except for identified cost transfers, each line of business, over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.

550.1610. Time for filing rate information and materials; notice of filing; approval

Sec. 610. (1) Except as provided under section 608(4) or (5), a filing of information and materials relative to a proposed rate shall be made not less than 120 days before the proposed effective date of the proposed rate. A filing shall not be considered to have been received until there has been substantial and material compliance with the requirements prescribed in subsections (6) and (8).

(2) Within 30 days after a filing is made of information and materials relative to a proposed rate, the commissioner shall do either of the following:

(a) Give written notice to the corporation, and to each person described under section 612(1), that the filing is in material and substantial compliance with subsections (6) and (8) and that the filing is complete. The commissioner shall then proceed to approve, approve with modifications, or disapprove the rate filing 60 days after receipt of the filing, based upon whether the filing meets the requirements of this act. However, if a hearing has been requested under section 613, the commissioner shall not approve, approve with modifications, or disapprove a filing until the hearing has been completed and an order issued.

(b) Give written notice to the corporation that the corporation has not yet complied with subsections (6) and (8). The notice shall state specifically in what respects the filing fails to meet the requirements of subsections (6) and (8).

(3) Within 10 days after the filing of notice pursuant to subsection (2)(b), the corporation shall submit to the commissioner such additional information and materials, as requested by the commissioner. Within 10 days after receipt of the additional information and materials, the commissioner shall determine whether the filing is in material and substantial compliance with subsections (6) and (8). If the commissioner determines that the filing does not yet materially and substantially meet the requirements of subsections (6) and (8), the commissioner shall give notice to the corporation pursuant to subsection (2)(b) or use visitation of the corporation's facilities and examination of the corporation's records to obtain the necessary information described in the notice issued pursuant to subsection (2)(b). The commissioner shall use either procedure previously mentioned, or a combination of both procedures, in order to obtain the necessary information as expeditiously as possible. The per diem, traveling, reproduction, and other necessary expenses in connection with visitation and examination shall be paid by the corporation, and shall be credited to the general fund of the state.

(4) If a filing is approved, approved with modifications, or disapproved under subsection (2)(a), the commissioner shall issue a written order of the approval, approval with modifications, or disapproval. If the filing was approved with modifications or disapproved, the order shall state specifically in what respects the filing fails to meet the requirements of this act and, if applicable, what modifications are required for approval under this act. If the filing was approved with modifications, the order shall state that the filing shall take effect after the modifications are made and approved by the commissioner. If the filing was disapproved, the order shall state that the filing shall not take effect.

(5) The inability to approve 1 or more rating classes of business within a line of business because of a requirement to submit further data or because a request for a hearing under section 613 has been granted shall not delay the approval of rates by the commissioner which could otherwise be approved or the implementation of rates already approved, unless the approval or implementation would affect the consideration of the unapproved classes of business.

(6) Information furnished under subsection (1) in support of a nongroup rate filing shall include the following:

(a) Recent claim experience on the benefits or comparable benefits for which the rate filing applies.

(b) Actual prior trend experience.

(c) Actual prior administrative expenses.

(d) Projected trend factors.

(e) Projected administrative expenses.

(f) Contributions for risk and contingency reserve factors.

(g) Actual health care corporation contingency reserve position.

(h) Projected health care corporation contingency reserve position.

(i) Other information which the corporation considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(j) Other information which the commissioner considers pertinent to evaluating the risks to be rated, or relevant to the determination to be made under this section.

(7) A copy of the filing, and all supporting information, except for the information which may not be disclosed under section 604, shall be open to public inspection as of the date filed with the commissioner.

(8) The commissioner shall make available forms and instructions for filing for proposed rates under sections 608(1) and 608(2). The forms with instructions shall be available not less than 180 days before the proposed effective date of filing.

550.1611. Legislative intent to promote uniformity of rates

Sec. 611. It is the intent of the legislature to promote uniformity of rates among subscribers to the greatest extent practicable.

550.1612. Notice of rate filings; fees for copies

Sec. 612. (1) Upon receipt of a rate filing under section 610, the commissioner immediately shall notify each person who has requested in writing notice of those filings within the previous 2 years, specifying the nature and extent of the proposed rate revision and identifying the location, time, and place where the copy of the rate filing described in section 610(7) shall be open to public inspection and copying. The notice shall also state that if the person has standing, the person shall have, upon making a written request for a hearing within 60 days after receiving notice of the rate filing, an opportunity for an evidentiary hearing under section 613 to determine whether the proposed rates meet the requirements of this act. The request shall identify the issues which the requesting party asserts are involved, what portion of the rate filing is requested to be heard, and how the party has standing. The corporation shall place advertisements giving notice, containing the information specified above, in at least 1 newspaper which serves each geographic area in which significant numbers of subscribers reside.

(2) The commissioner may charge a fee for providing, pursuant to subsection (1), a copy of the rate filing described in section 610(7). The commissioner may charge a fee for providing a copy of the entire filing to a person whose request for a hearing has been granted by the commissioner pursuant to section 613. The fee shall be limited to actual mailing costs and to the actual incremental cost of duplication, including labor and the cost of deletion and separation of information as provided in section 14 of Act No. 442 of the Public Acts of 1976, being section 15.244 of the Michigan Compiled Laws. Copies of the filing may be provided free of charge or at a reduced charge if the commissioner determines that a waiver or

reduction of the fee is in the public interest because the furnishing of a copy of the filing will primarily benefit the general public. In calculating the costs under this subsection, the commissioner shall not attribute more than the hourly wage of the lowest paid, full-time clerical employee of the insurance bureau to the cost of labor incurred in duplication and mailing and to the cost of separation and deletion. The commissioner shall use the most economical means available to provide copies of a rate filing.

550.1613. Hearings on rate filings; standing; decisions

Sec. 613. (1) If the request for a hearing under this section is with regard to a rate filing not yet acted upon under section 610(2)(a), no such action shall be taken by the commissioner until after the hearing has been completed. However, the commissioner shall proceed to act upon those portions of a rate filing upon which no hearing has been requested. Within 15 days after receipt of a request for a hearing, the commissioner shall determine if the person has standing. If the commissioner determines that the person has standing, the person may have access to the entire filing subject to the same confidentiality requirements as the commissioner under section 604, and shall be subject to the penalty provision of section 604(5). Upon determining that the person has standing, the commissioner shall immediately appoint an independent hearing officer before whom the hearing shall be held. In appointing an independent hearing officer, the commissioner shall select a person qualified to conduct hearings, who has experience or education in the area of health care corporation or insurance rate determination and finance, and who is not otherwise associated financially with a health care corporation or a health care provider. The person selected shall not be currently or actively employed by this state. For purposes of this subsection, an employee of an educational institution shall not be considered to be employed by this state. For purposes of this section, a person has "standing" if any of the following circumstances exist:

(a) The person is, or there are reasonable grounds to believe that the person could be, aggrieved by the proposed rate.

(b) The person is acting on behalf of 1 or more named persons described in subdivision (a).

(c) The person is the commissioner, the attorney general, or the health care corporation.

(2) Not more than 30 days after receipt of a request for a hearing, and upon not less than 15 days' notice to all parties, the hearing shall be commenced. Each party to the hearing shall be given a reasonable opportunity for discovery before and throughout the course of the hearing. However, the hearing officer may terminate discovery at any time, for good cause shown. The hearing officer shall conduct the hearing pursuant to the administrative procedures act. The hearing shall be conducted in an expeditious manner. At the hearing, the burden of proving compliance with this act shall be upon the health care corporation.

(3) In rendering a proposal for a decision, the hearing officer shall consider the factors prescribed in section 609.

(4) Within 30 days after receipt of the hearing officer's proposal for decision, the commissioner shall by order render a decision which shall include a statement of findings.

(5) The commissioner shall withdraw an order of approval or approval with modifications if the commissioner finds that the filing no longer meets the requirements of this act.

550.1614. Interim rates

Sec. 614. (1) Not less than 75 days after a filing is received, as provided in section 610, the health care corporation may petition the commissioner, who shall make a determination with respect to interim rates and shall order interim rates in the amount prescribed in subsection (2). Interim rates shall not be implemented if the commissioner finds that the health care corporation has substantially contributed to the delay or that the health care corporation has not provided information requested by the commissioner relative to a determination

under this section. The interim rate determination shall not be a contested case under chapter 4 of the administrative procedures act.

(2) The commissioner shall grant an interim rate, in an amount as determined by the commissioner, if the commissioner makes a finding that the corporation has made a convincing showing that there is probable cause to believe that the failure to grant the interim rate will result in an underwriting loss for that line of business for the period for which rates are being requested. As used in this subsection, "underwriting loss" means the difference between income from current rates plus investment income, and projected claims plus projected administrative expenses.

(3) If the final rate determination results in approval of a lower rate, appropriate refunds or adjustments, as determined by the commissioner, shall be made to reflect payments made in excess of the approved rate.

(4) The order establishing an interim rate adjustment made pursuant to this section shall be limited to adjusting rates for certificates then in effect, and shall not be used to alter certificates or implement new certificates.

(5) This section shall apply only to rates subject to section 608(1) for which a hearing has been requested.

550.1615. Review of final orders or decisions after hearing

Sec. 615. Any final order or decision made, issued, or executed by the commissioner under this act after a hearing held before the commissioner or a deputy commissioner pursuant to the administrative procedures act shall be subject to review as provided in chapter 6 of the administrative procedures act without leave by the circuit court for Ingham county.

550.1616. Endorsement of documents filed; refusal to file; corrections

Sec. 616. (1) If a document required or permitted to be filed with the commissioner under this act substantially conforms to the requirements of this act, the commissioner shall

endorse upon it the word "filed" with the commissioner's official title and the dates of receipt and of filing, and shall file and index the document or a microfilm or other reproduced copy of the document in his or her office. If so requested at the time of delivery of the document to his or her office, the commissioner shall include the hour of filing in his or her endorsement on the document.

(2) If the commissioner fails promptly to file a document, other than an annual report or a supplemental statement, submitted for filing under this act, the commissioner shall, within 10 days after receipt from the person submitting the document for filing of a written request for the filing of the document, give written notice of the refusal to file to that person, specifying the reasons for the failure to file the document. From the disapproval the person may seek judicial review pursuant to sections 103, 104, and 106 of the administrative procedures act.

(3) If a document relating to a health care corporation filed with the commissioner under this act is an inaccurate record of the corporation action referred to in the document or was defectively or erroneously executed, the document may be corrected by filing with the commissioner a certificate of correction on behalf of the corporation. A certificate, entitled "certificate of correction of . . . (correct title of document and name of corporation)" shall be signed as provided in this act with respect to the document being corrected and filed with the commissioner. The certificate shall set forth the name of the corporation, the date the document to be corrected was filed by the commissioner, the provision in the document as corrected or eliminated, and if the execution was defective, the proper execution. The corrected document is effective in its corrected form as of its original filing date except as to a person who relied upon the inaccurate portion of the document and was, as a result of the inaccurate portion of the document, adversely affected by the correction.

(4) This section shall not apply with respect to documents filed pursuant to part 5 or this part.

550.1617. Rules

Sec. 617. The commissioner may promulgate rules which the commissioner considers necessary to carry out the purposes of, and to execute and enforce this act. The rules shall be promulgated pursuant to the administrative procedures act.

550.1618. Time for compliance with requirements

Sec. 618. Whenever any section of this act requires a health care corporation to implement any new procedure, provide any new benefit, or enter into any new contract, the commissioner shall give the health care corporation a reasonable time to comply with the requirements.

550.1619. Injunctions; declaratory and equitable relief

Sec. 619. (1) The attorney general may bring an action, or apply to the circuit court for a court order, to enjoin a health care corporation from transacting business, receiving, collecting, or disbursing money, or acquiring, holding, protecting, or conveying property if that corporate activity is not authorized under this act.

(2) The attorney general may apply to the circuit court for a court order enjoining an alleged violation of this act or other equitable or extraordinary relief to enforce this act.

(3) A political subdivision of this state, an agency of this state, or any person may bring an action in the circuit court for Ingham county for declaratory and equitable relief against the commissioner or to compel the commissioner to enforce this act or rules promulgated under this act.

PART 7.

550.1701. Continuation of existence; conformance to act

Sec. 701. (1) Each health care corporation on the effective date of this act shall be subject to this act without formal reorganization under this act, and shall be considered to exist under this act. However, within 120 days following the effective date of this act, the health care corporation shall do all of the following:

(a) Amend its articles of incorporation and bylaws to conform to the requirements of this act, subject to the certification of the attorney general, as provided in subsection (2).

(b) Restructure its board of directors to conform with the requirements of this act. The restructuring shall be described, shall be in writing, and shall be subject to the certification of the attorney general, as provided in subsection (2).

(c) After complying with subdivisions (a) and (b), obtain from the commissioner a new certificate of authority.

(2) Relative to the changes required by this act, amendments to the articles and bylaws, and a written description of the board restructuring shall be submitted to the attorney general and to the commissioner. If the attorney general finds that the amendments and restructuring conform to all statutory requirements, and that they comply with this act and ensure fair and equitable representation of the subscribers of the corporation, the attorney general shall certify these findings to the commissioner. In reviewing the amendments and description of the board restructuring, the attorney general may consult with the board of directors, officers, or employees of a corporation, and with any other individual or organization.

(3) If the attorney general approves the amendments and restructuring, the attorney general shall certify his or her approval to the board. The amendments, and restructuring as described, shall take effect 10 days after the certification. If the attorney general disapproves all or any part of the amendments or restructuring, or both, the attorney general shall return the disapproved amendments or the written description of the restructuring, or both, to the board with a written statement setting forth the reasons for the disapproval and any recommendations for change which he or she may wish to suggest.

(4) If the amendments, written description of restructuring, or both, required by this act are not submitted to the attorney general and the commissioner within 120 days after the effective date of this act, or if the amendments, written description, or both, are disapproved as provided in this section, the

commissioner and the attorney general shall, and the corporation may, seek judiciai remedies as provided for by law in the circuit court in this state.

(5) If a health care corporation fails to comply with this section, the commissioner may issue an order suspending the right and privilege of the corporation to sell or issue new certificates until this section has been fully complied with.

(6) The corporate existence of each health care corporation operating in this state shall be considered to be extended, and its powers in all other respects undiminished, during the 120-day implementation period prescribed in subsection (1).

550.1702. Continuation of rules, orders or approvals

Sec. 702. Rules which were promulgated under former Act No. 108 or 109 of the Public Acts of 1939, shall not continue in effect under this act. Orders issued and approvals granted by the commissioner under former Act No. 108 or 109 of the Public Acts of 1939, shall continue in effect until rescinded or withdrawn by the commissioner under this act.

550.1703. Repealer

Sec. 703. The following acts and parts of acts are repealed:

(a) Act No. 108 of the Public Acts of 1939, as amended, being sections 550.301 to 550.316 of the Compiled Laws of 1970.

(b) Act No. 109 of the Public Acts of 1939, as amended, being sections 550.501 to 550.517 of the Compiled Laws of 1970.

550.1704. Effective date

Sec. 704. This act shall take effect April 3, 1981.